STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555709	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Global Medical Center D/P Snf	2601 East Chapman Avenue Orange, CA 92869

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility's P&P review, the facility failed to provide a homelike, clean and comfortable environment for five of ten residents rooms. * The facility failed to ensure Resident 8's room was free with water mark discoloration in the ceiling. In addition, the facility failed to ensure the window blinds for rooms [ROOM NUMBER] were not missing panels. * The facility failed to ensure Resident 9's privacy curtains were well maintained and not off the hook. * The facility failed to ensure Resident 23's GT feeding pole stand was clean and free from brownish, dirt like particles. * The facility failed to ensure the window blinds for room [ROOM NUMBER] were not missing panels. These failures had the potential for the residents to not have a clean, comfortable, homelike environment and could negatively affect the residents' well-being.Findings: Review of the facility's Infection Prevention 2026 Annual Plan: 2026 Strategies to Minimize, Reduce and Eliminate Infection Risk (undated) showed regular rounding will be conducted to evaluate Environment of Care by Plant Operations, Environmental Services and infection Prevention. Review of the facility's P&P titled Environmental Surveillance Rounds revised date 8/2009 showed the facility conducts environmental tours to identify environmental deficiencies, hazards, and unsafe practices. Environmental tours are conducted every six months in patient care areas to evaluate the effectiveness of previously implemented activities intended to minimize or eliminate environment of care risks. 1. On 4/6/26 at 834 hours, during the initial tour to the facility, the extendable middle section of Resident 23's GT feeding pole stand was observed with brownish, dirt like particles. On 4/6/26 at 900 hours, an interview was conducted with CNA 3. The extendable middle section of Resident 23's GT feeding pole stand was shown to CNA 3. CNA 3 verified and stated it is dirty, I don't know what that is for. On 4/7/26 at 1031 hours, an interview was conducted with Environmental Services Staff 1. Environmental Services Staff 1 verified the extendable middle section of Resident 23's GT feeding pole stand had brownish, dirt like particles. Environmental Services Staff 1 stated it was dirty and it needed to be replaced. 2. On 4/8/25 at 952 hours, a medication administration observation was conducted with LVN 6 in Resident 9's room. Resident 9's privacy curtain was observed to be hanging off the hook, approximately five hooks were missing. On 4/8/26 at 1050 hours, an observation and concurrent interview was conducted with the DSD. 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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	DSD verified Resident 9's privacy curtain was partially hanging off the hook. The DSD stated they should fix this, I will let housekeeping know. On 4/8/26 at 1115 hours, an interview was conducted with the Environmental Services Director. The Environmental Services Director was informed the privacy curtain was partially off the hook in Resident 9's room. The Environmental Services Director acknowledged and stated he will have them replaced and it was a priority. On 4/9/26 at 1336 hours, an interview was conducted with the DON. The DON verified Resident 9's privacy curtain is partially hanging off the hook. The DON stated the housekeeping/environmental services were assigned on the curtains. The DON further stated when they do deep cleaning, they should look up and check these curtains, we have discharges almost every day. 3. On 4/06/2026 at 0853 hours, during the initial tour of the facility, Resident 8 was observed in bed awake, alert and able to respond by sign gestures. Resident 8 pointed towards the ceiling of his room. Resident 8's room ceiling corner was observed with grayish to black discoloration. In addition, Resident 8's window had missing blinds panels. Medical record review for Resident 8 was initiated on 4/6/26. Resident 8 was admitted to the facility on [DATE]. On 4/07/2026 at 1023 hours, an observation and concurrent interview with LVN 1 was conducted at Resident 8's room. LVN 1 was informed about Resident 8's room ceiling concerns and the missing window blind panels. LVN 1 verified and acknowledged the observation in Resident 8's room. LVN 1 stated the DON and the Maintenance Supervisor were made aware about the concerns. On 4/07/2026 at 1037 hours, additional observation and concurrent interview with Maintenance Supervisor in Resident 8's room and Resident's rooms [ROOM NUMBER] was conducted. The Maintenance Supervisor was asked about Resident 8's room ceiling. The Maintenance Supervisor verified Resident 8's ceiling had grayish to black discoloration. The Maintenance Supervisor stated they fixed the ceiling before; however, due to all the drainage going through on the section on the roof, there was condensation and it would seep through the barrier they placed. The Maintenance Supervisor was also made aware of the missing window blind panels on rooms [ROOM NUMBER]. The Maintenance Supervisor verified and acknowledged the findings. On 4/09/2026 at 1501 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. On 4/7/26 at 0956 hours, an observation in room [ROOM NUMBER] was conducted. There were three missing panels from the window blinds. Residents 10, 16, 18, and 24 were observed laying in their beds. On 4/7/26 at 1025 hours, an observation and concurrent interview was conducted in room [ROOM NUMBER] with the Maintenance Supervisor. The Maintenance Supervisor verified the above finding and stated the missing blind panels should have been replaced. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure three of five licensed nurses (LVNs 7, 8, and 10) demonstrated the competencies needed to provide safe nursing care. * LVNs 7, 8, and 10 failed to disconnect the residents from the GT extension tubing when the residents' GT feeding reached the formula dose limit or after the feeding formula was completed. These failures had the potential to put the residents at risk for enteral feeding care not provided in a safe and competent manner.Findings Review of the facility's P&P titled Enteral Feeding revised 12/2020 showed to review the order for feedings such as formula, dose limit, rate, and number of hours for infusion per physician orders. In addition, to check the GT placement by auscultating air and to check feeding residual by aspirating stomach content. Lastly, to discontinue the tube feeding when volume dose limit was reached. Review of the facility's document titled Call Lights, Feeding Supervision, and Disconnection of Tubes in-service dated 2/3/26, showed a summary of the in-service included instructions to disconnect residents from the GT(s).1. Medical record review for Resident 20 was initiated on 4/6/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 9/19/25, showed Resident 20 had a diagnosis of severe traumatic brain injury and was a GT dependent. Review of Resident 20's Patient Orders showed a physician's order dated 2/17/26, to administer Vital AF 1.2 formula via PEG tube at 90 ml/hr daily, to provide a total of 1800 ml/2160 kcals to administer via enteral pump via GT, and to start the tube feeding infusion at 0600 hours until the total dose was completed. On 4/8/26 at 0522 hours, Resident 20 was observed asleep with the head of the bed elevated. Resident 20 was observed connected to a GT extension tubing with Vital AF 1.2 formula (feeding formula) dated 4/7/26 at 1900 hours. The enteral pump was off. On 4/8/26 at 0537 hours, an observation for Resident 20 and concurrent interview was conducted with LVN 7. LVN 7 was observed donning a gown and gloves prior to entering Resident 20's room. LVN 7 stated Resident 20's enteral feedings were administered at 0600 hours daily and would infuse for 20 hours. LVN 7 stated Resident 20's GT feeding was completed at 0400 hours. When asked if the GT extension tubing should be disconnected after each dose was completed, LVN 7 stated no. LVN 7 turned on the GT enteral pump and began to administer the GT formula. 2. Medical record review for Resident 3 was initiated on 4/6/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 5/31/25, showed Resident 3 had a GT. Review of Resident 3's Patient Orders showed a physician's order dated 3/17/26, to administer Vital AF 1.2 formula via GT at 70 ml/hr, to provide a total of 1400 ml/1680 kcals to administer via enteral pump via GT, and to start the tube feeding infusion at 0600 hours until total dose was completed. On 4/8/26 at 0537 hours, Resident 3 was observed in bed with the head of the bed elevated. Resident 3 was observed connected to a GT extension tubing with Vital AF 1.2 formula dated 4/7/26 at 2000 hours and a water bag dated 4/7/26 at 0600 hours. The enteral pump was off. On 4/8/26 at 0540 hours, an interview and concurrent observation for Resident 3 was conducted with LVN 8. LVN 8 was observed donning a gown and gloves prior to entering Resident 3's room. LVN 8 stated Resident 3 completed her GT formula at 0300 hours. LVN 8 further stated that when GT feedings reached the dose limit, the licensed staff members would turn off the machine and keep the residents connected to the GT extension tubing until the next scheduled feeding. 3. On 4/8/26 at 0540 hours, an interview was conducted with LVN 10. LVN 10 stated most residents in the facility received continuous GT feedings for 20 hours and completed their dosage at around 0300 or 0400 hours. When the GT feedings reached their dose limit, the residents would stay connected to the GT extension tubing until the next feeding at around 0600 hours. On 4/8/26 at 0604 hours, an interview was conducted with RN 2. RN 2 stated when the resident reached the GT formula dose limit, the licensed staff members were expected to turn off the enteral pump and disconnect the resident (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the GT extension tubing. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON stated when the resident reached the GT formula dose limit, the licensed staff members were expected to clear the settings of the enteral pump, then disconnect the resident from the GT extension tubing. The DON was made aware about LVNs 7, 8 and 10 who left the residents connected to the GT extension tubing when the GT feeding reached the formula dose limit. The DON acknowledged the above findings. Cross reference to F693

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, facility document review, and facility P&P review, the facility failed to provide the necessary pharmacy services for five of 12 final sampled residents (Residents 3, 12, 13, 20 and 21), five nonsampled residents (Residents 5, 9, 10, 16, and 18) and for three of seven medication carts (Medication Carts A, C, and D) to ensure proper storage and labeling of the medications. * Medication Cart A had multiple colored stains, dust and rust-like particles. Additionally, there were expired wound supplies and culture and sensitivity tests. * Medication Cart C had internal and external medications stored together in the same drawer. Additionally, Resident 3's Lantus medication was expired. * Medication Cart D had rust on the mid-base of the first drawer. * The facility failed to ensure Resident 3, 5, 9, 10,12, 13 16, 18, 20, and 21's opened bottle of normal saline solution was discarded after 24 hours. * The facility failed to ensure Resident 20's vitamin E topical cream (a potent antioxidant moisturizer that hydrates, nourishes and protects the skin) and calazime cream (a topical skin protectant) were not left unattended by the licensed nurse on top of Resident 20's bedside table. These failures had the potential to have negative impact on the residents' well-being, and the potential for the medications to be contaminated, losing the stability, and effectiveness.Findings: Review of the facility's P&P titled Medication Storage and Security dated 9/2023 showed the following:- the purpose is to ensure that medications are stored and handled in conditions that maintain the integrity and potency of the products;- external use medications in liquid, tablet, capsule or powder shall be segregated from medications intended for internal use;- medications shall be accessible only to hospital personnel authorized to receive, store, distribute, or administer medications; - medications and biologicals are stored in a manner to prevent unmonitored access by unauthorized individuals; and- all expired, damaged, and/or contaminated medications shall be removed from regular stock with the hospital. 1. On [DATE] at 0924 hours, an inspection of Medication Cart A was conducted with LVN 5. The following was observed:- in the first drawer, there was dust and brown rust- like particles on the floor base of the drawer, an opened packet of single use only Puracol (used for wound management) Ultra powder which was cut in half with white powder inside, and an opened and exposed packet of Duoderm (wound dressing) without the original packet;- in the fourth drawer, there was a brownish black spot with dirt like particles. The cart liners were wet;- in the fifth drawer, there were yellow/brownish stains to the cart lining;- in the sixth drawer, there were red, yellow & brown particles and stains on the floor of the drawer;- in the eighth drawer, there was a brown stained dermal curette (used to debride wounds) without an expiration date. Additionally, there were four expired culture and sensitivity (used to store specimen for culture & sensitivity tests) test kits with an expiration date of [DATE]; and- in the ninth drawer, there were eight expired culture and sensitivity test kits with an expiration date of [DATE]. LVN 5 verified the above findings. 2.a. On [DATE] at 1047 hours, an inspection of Medication Cart C was conducted with LVN 1. There were internal and external medications stored together in the last drawer, chlorhexidine bottles (used as an antiseptic and disinfectant during resident's showers) stored with Beneprotein Fiber (fiber supplement), sucralfate tablets (medication used to treat and prevent stomach ulcers) and Fleet enema (medication used for constipation). LVN 1 verified the findings. b. On [DATE] at 1130 hours, an inspection of Medication Cart C was conducted with LVN 6. Resident 3's Lantus (insulin) was dispensed from the pharmacy on [DATE], with a handwritten label opened date of [DATE] and expired on [DATE]. LVN 6 verified Resident 3's Lantus medication was expired [DATE], and insulin should have been discarded. LVN 6 stated insulin should be kept for 28 days from the open date and Resident 3's Lantus medication was more than 28 days. On [DATE] at 1145 hours, an observation of Resident 3's Lantus medication and concurrent interview was conducted with the DSD. The DSD (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	verified the Lantus medication was kept past the 28 days and was expired [DATE]. The DSD further verified it should have been discarded. 3. On [DATE] at 1115 hours, an inspection of Medication Cart D was conducted with LVN 4. There was rust on the mid-base of the first drawer. LVN 4 verified the findings and stated the pharmacy services were responsible to take care of the carts. On [DATE] at 1129 hours, an interview was conducted with the Lead Pharmacy Technician. The Lead Pharmacy Technician verified the rust like appearance on the mid-base of the first drawer. On [DATE] at 1343 hours, an interview was conducted with the DON. The DON acknowledged the above findings. 4. On [DATE] at 0809 hours, during the initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 21's nightstand. Medical record review for Resident 21 was initiated on [DATE]. Resident 21 was admitted to the facility on [DATE]. Review of Resident 21's MDS assessment dated [DATE], showed Resident 21 had severely impaired cognitive skills for daily decision making. Review of Resident 21's physician's orders showed the following:- dated [DATE], for tracheostomy site care every shift and PRN with half strength hydrogen peroxide (an antiseptic solution used to clean minor skin wounds) and normal saline; and- dated [DATE], to suction the tracheostomy every two hours. On [DATE] at 1018 hours, an observation for Resident 21 and concurrent interview was conducted with LVN 9. LVN 9 verified the opened normal saline solution bottle at Resident 21's nightstand was dated [DATE]. LVN 9 stated it should have been changed because it is only good for 24 hours. 5. On [DATE] at 0827 hours, during the initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 12's nightstand. Medical record review for Resident 12 was initiated on [DATE]. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated [DATE], showed Resident 12 was neurologically awake but had no other meaningful response. Review of Resident 12's physician's order date [DATE], showed to cleanse the tracheostomy site with half strength peroxide and normal saline and to suction the artificial airway for retained or increased secretions. On [DATE] at 1022 hours, an interview was conducted with LVN 2. LVN 2 was asked how many hours the normal saline was good for after the bottle was opened, after opening, LVN 2 responded 24 hours. LVN 2 was asked if only the RT would use the normal saline, LVN 2 stated they were also using the normal saline but did not know what happened. 6. On [DATE] at 0857 hours, during the initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 13's nightstand. Medical record for Resident 13 was initiated on [DATE]. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P examination dated [DATE], showed Resident 13 was awake, and non-communicative. Review of Resident 13's physician's orders showed the following:- dated [DATE], tracheostomy site care every shift and PRN with half strength hydrogen peroxide and normal saline; and- dated [DATE], to suction every two hours and PRN for retained or increased secretions. On [DATE] at 1020 hours, an observation for Resident 13 and concurrent interview was conducted with CNA 3. CNA 3 verified the opened normal saline bottle on top of Resident 13's nightstand was dated [DATE]. On [DATE] at 1026 hours, an observation and concurrent interview was conducted with the DSD. The DSD was observed labeling bottles of normal saline. The DSD was asked what he was doing, the DSD stated he was changing all the normal saline bottles at bedside. The DSD verified the opened bottles of normal saline on top of Resident 12, 13, and 21's nightstand had been open for more than 24 hours. The DSD further stated the normal saline bottles should have been used within 24 hours and then discarded. 7. Medical record review for Resident 20 was initiated on [DATE]. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated [DATE], showed Resident 20 had a diagnosis of severe traumatic brain injury and had a tracheostomy. Review of Resident 20's MDS assessment dated [DATE], under Section B, showed Resident 20 was at a persistent vegetative state and had no discernible consciousness. Review of Resident 20's physician's orders showed the following:- dated [DATE], to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and- dated [DATE], to apply vitamin E topical cream two times per day and as needed on Resident 20's buttocks. In addition, the vitamin E cream (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was mixed with calazime cream mixture. a. On [DATE] at 0920 hours, during initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 20's nightstand. b. On [DATE] at 0522 hours, a pink paste inside a disposable medication cup was observed on top of Resident 20's bedside table. On [DATE] at 0537 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 verified the pink paste was a mixture of Resident 20's vitamin E topical cream and calazime cream. LVN 7 further stated the medication paste should not have been left on Resident 20's bedside table. 8. On [DATE] at 0902 hours, during initial tour of the facility, an opened normal saline bottle dated [DATE], was observed on top of Resident 9's nightstand. Medical record review for Resident 9 was initiated on [DATE]. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated [DATE], showed Resident 9 had a tracheostomy. Review of Resident 9's physician's order dated [DATE], showed to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and to provide suctioning as needed for retained or increased respiratory secretions. 9. On [DATE] at 0925 hours, during initial tour of the facility, an open and undated normal saline bottle was observed on top of Resident 5's nightstand. Medical record review for Resident 5 was initiated on [DATE]. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated [DATE], showed Resident 5 had a tracheostomy. Review of Resident 5's physician's order dated [DATE], showed to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and to provide suctioning every two hours and as needed for retained or increased respiratory secretions. 10. On [DATE] at 0930 hours, during initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 3's nightstand. Medical record review for Resident 3 was initiated on [DATE]. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated [DATE], showed Resident 3 had a tracheostomy. Review of Resident 3's physician's order dated [DATE], showed to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and to provide suctioning every two hours and as needed for retained or increased respiratory secretions. 11. On [DATE] at 0947 hours, during initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 16's nightstand. Medical record review for Resident 16 was initiated on [DATE]. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's H&P examination dated [DATE], showed Resident 16 had a tracheostomy. Review of Resident 16's physician's order dated [DATE], showed to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and to provide suctioning every two hours and as needed for retained or increased respiratory secretions. 12. On [DATE] at 0950 hours, during initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 10's nightstand. Medical record review for Resident 10 was initiated on [DATE]. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's H&P examination dated [DATE], showed Resident 10 had a tracheostomy. Review of Resident 10's physician's order dated [DATE], showed to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and to provide suctioning every two hours and as needed for retained or increased respiratory secretions. 13. On [DATE] at 0955 hours, during initial tour of the facility, an open normal saline bottle dated [DATE], was observed on top of Resident 18's nightstand. Medical record review for Resident 18 was initiated on [DATE]. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated [DATE], showed Resident 18 had a tracheostomy. Review of Resident 18's physician's order dated [DATE], showed to cleanse the tracheostomy site every shift with half strength hydrogen peroxide and normal saline, and to provide suctioning every two hours and as needed for retained or increased respiratory secretions. On [DATE] at 1012 hours, a follow-up observation for Residents 3, 5, 9, 10, 16, 18, and 20 and concurrent interview was conducted with RN 1. RN 1 stated the normal saline bottles should be dated and opened bottles of normal saline is stored only for 24 hours, then should be discarded after. RN 1 stated the normal saline bottles were used by the RT to cleanse the residents' tracheostomy sites and to clear (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the suction from the residents' respiratory secretions. RN 1 verified the opened bottle of normal saline on top of Resident 3, 5, 9, 10, 16, 18 and 20's nightstand were stored for more than 24 hours.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on interview and facility P&P review, the facility failed to ensure safe food handling of the food brought for the residents from outside sources. * The facility failed to ensure the facility staff members who handled the outside food demonstrated competency on safe food handling procedures. This failure posed the risk of food contamination which could lead to food borne illness for three residents who consumed food by mouth. Findings: Review of the facility's P&P titled Food from an Outside Source dated 2/2000 showed the guidelines for storing food in the nursing units included to label all containers with the resident's name, medical record number, and date. The food will be discarded within 48 hours unless the manufacturer's expiration date was present. On 4/8/26 at 1522 hours, an interview was conducted with RN 1. RN 1 was asked to explain the process when the visitors would bring food for the residents from outside sources. RN 1 stated the facility staff members would educate the resident and their visitors regarding the facility's policy, then the facility staff members would check the resident's diet order, date, and label the food item. When asked how long the food brought in from outside sources could stay in the resident's refrigerator, RN 1 stated for three days. On 4/9/26 at 0809 hours, an interview was conducted with LVN 11. LVN 11 was asked for how long the food brought in from outside sources could stay in the resident's refrigerator, LVN 11 stated for 24 hours. On 4/9/26 at 0815 hours, an interview was conducted with RN 3. RN 3 was asked for how long the food brought in from outside sources could stay in the resident's refrigerator, RN 3 stated for 24 hours. On 4/9/26 at 0818 hours, an interview was conducted with LVN 12. LVN 12 was asked for how long the food brought in from outside sources could stay in the resident's refrigerator, LVN 12 stated for 72 hours. On 4/9/26 at 0827 hours, an interview was conducted with the Director of Food and Nutrition Services. The Director of Food and Nutrition Services stated the nursing staff members would educate the visitors who would bring residents' food from outside sources regarding the facility's policy. In addition, the nursing staff members could utilize the registered dietitian or himself as a resource to ensure the food item was not contra-indicated to the resident's diet. Furthermore, nursing staff members should label and date the food item and should discard the food item after two days. On 4/9/26 at 1323 hours, an interview was conducted with the DSD. The DSD was asked for how long the food brought in from outside sources could stay in the resident's refrigerator, the DSD stated within 72 hours and the food item should be dated and labeled. On 4/9/26 at 1332 hours, an interview was conducted with CNA 4. CNA 4 was asked for how long the food brought in from outside sources could stay in the resident's refrigerator, CNA 4 stated she was unsure but would ask RN 3. CNA 4 stated food items could stay in the refrigerator for one day. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON stated the food items brought by outside sources should not contra-indicate the resident's diet, should be labeled and dated, and should be discarded after 48 hours or the manufacturer's expiration date. The DON was informed and acknowledged the above findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555709	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Global Medical Center D/P Snf	2601 East Chapman Avenue Orange, CA 92869

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections. * The facility failed to implement the infection control surveillance program for the months of October 2025 through March 2026. The facility conducted surveillance of the residents infections only when the residents were prescribed an antimicrobial medications and/or if the residents were diagnosed with an infection. * The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications, or had not been diagnosed with an infection, met the facility's criteria for infection (utilizing McGeer's Criteria). In addition, the facility failed to include these residents in the facility's infection control surveillance program. These failures posed the risk of not identifying residents' infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: Review of the facility's P&P titled Infection Control Performance Improvement Program Plan revised 7/2023 showed an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The infection prevention and control program is coordinated and overseen by the IP. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. The information obtained from infection control surveillance activities is compared with acknowledged standards and used to assess effectiveness of established infection prevention and control practices. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from October 2025 through March 2026 showed the following infection surveillance data of the number of the resident who was classified to have HAIs, CAIs, and the residents who did not meet McGeer's Criteria (DNMC):- for 10/1025: HAI - 3, CAI - 0, and DNMC - 0;- for 11/2025: HAI - 2, CAI - 0, and DNMC - 0;- for 12/2025: HAI - 1, CAI - 0, and DNMC - 0;- for 1/2026: HAI - 4, CAI - 0, and DNMC - 0;- for 2/2026: HAI - 2 , CAI - 0, and DNMC - 0; and - for 3/2026: HAI - 2 , CAI - 0 , and DNMC - 0. On 4/9/26 at 0832 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's resident infection surveillance program. The IP stated when a resident was prescribed an antimicrobial medications or was diagnosed with an infection, the facility would then initiate a McGeer's Criteria and/or Loeb's Criteria form. The IP stated the McGeer's Criteria was utilized to determine if a resident had a true infection. The IP stated the Loeb's Criteria was utilized to determine whether a resident met the minimum criteria for the use of the antibiotics. Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from October 2025 through March 2026 showed all of the residents included in the facility's infection surveillance program were determined to have either a HAI or CAI (with prescribed antimicrobial medications or having been diagnosed with an infection). The Infection Prevention and Control Surveillance logs failed to show any residents who did not meet McGeer's criteria. The IP verified no residents in the facility were classified as having not met the McGeer's Criteria between the months of October 2025 through March 2026. When the IP was asked if the facility included the residents in the facility's infection surveillance program when a resident at the facility exhibited signs and/or symptoms of an infection and was not prescribed antimicrobial medications (or was not diagnosed with an infection) when the facility initiated the McGeer's criteria form, the IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications (or were not diagnosed with an infection). The IP was asked how many residents had met the McGeer's criteria and were not prescribed antimicrobial medications from October 2025 through March 2026 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(excluding residents who were diagnosed with an infection). The IP stated she was uncertain, as the facility did not initiate the McGeer's criteria form for those residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications (or had not been diagnosed with an infection). On 4/9/26 at 1501 hours, an interview and concurrent facility document review was conducted with the DON. The DON was informed and verified the above findings.

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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 ensure the dignity was maintained for one of 12 final sampled residents (Resident 6) and one nonsampled resident (Resident 14). * The facility failed to ensure Resident 6's and 14's indwelling urinary catheter drainage bag was covered. This failure had the potential to affect the residents' well-being.Findings: 1. On 4/6/26 at 0903 hours and 4/7/26 at 0924 hours, Resident 6 was observed in bed with the indwelling urinary catheter drainage bag at the side of the bed uncovered. Medical record review for Resident 6 was initiated on 4/7/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's MDS assessment dated [DATE], showed Resident 6 had severe cognitive impairment and needed total assistance from the staff on all ADL care. On 4/07/2026 at 1326 hours, an observation and concurrent interview for Resident 6 was conducted with CNA 2. CNA 2 stated Resident 6 had an indwelling urinary catheter and she would empty the catheter drainage bag at the end of her shift. CNA 2 verified and acknowledged the catheter drainage bag did not have a privacy bag. CNA 2 stated the drainage bag should be on a privacy bag. 2. On 4/06/2026 at 0836 hours and 4/7/26 at 0701 hours, Resident 14 was observed in bed with the indwelling urinary catheter drainage bag at the side of the bed uncovered. Medical record review for Resident 14 was initiated on 4/7/26. Resident 14 was admitted to the facility on [DATE]. Review of Resident 14's Order Summary Report showed a physician's order dated 6/6/25, to provide an indwelling urinary catheter care every shift. On 4/07/2026 at 1415 hours, an observation and concurrent interview for Resident 14 was conducted with CNA 1. CNA 1 stated Resident 14 had an indwelling urinary catheter and he would empty the catheter drainage bag at the end of his shift. CNA 1 verified and acknowledged the catheter drainage bag did not have a privacy bag. CNA 1 stated the drainage bag should be on a privacy bag. On 4/07/2026 at 1430 hours, an observation and concurrent interview for Residents 6 and 14 was conducted with LVN 1. LVN 1 verified and acknowledged Residents 6 and 14 use of the indwelling urinary catheter. LVN 1 verified and acknowledged the indwelling urinary catheter drainage bag at the side of Residents 6 and 14 was not on a privacy bag. LVN 1 stated the indwelling urinary catheter drainage bag should be placed on a privacy bag. On 4/09/2026 at 1501 hours, an interview and concurrent medical record review for Residents 6 and 14 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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's P&P review, the facility failed to ensure one of five residents (Resident 7) reviewed for the unnecessary medications was free from the unnecessary psychoactive medications. * The facility failed to ensure an informed consent was completed prior to Resident 7's use of valproic acid (mood stabilizer) as manifested by angry outburst and duloxetine (antidepressant) medications. These failures had the potential for the resident to receive unnecessary medications and negatively affect the resident's health.Findings Review of the facility's P&P titled Psychoactive/Chemical Restraint dated 3/2026 showed the residents will receive psychoactive medications only when they are necessary to treat medical, mood, behavioral or psychiatric symptom. To obtain informed consent from resident's rep if resident lacks decisional capacity. Review of the facility's P&P titled Informed Consent dated 3/2026 showed all the residents medical records must contain a properly executed informed consent documentation for any procedures and treatments specified by the policy and procedure manual, medical staff rules and regulations, or state or federal law or regulations that require an informed consent. The properly executed informed consent must be placed in the resident's medical record prior to initiation of medication use. An informed consent is required for use of antipsychotic medications. Review of Resident 7's medical record was initiated on 4/6/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's MDS assessment dated [DATE], showed BIMS score of 99 (unable to complete the interview). Review of Resident 7's Patient Orders showed the following orders:- dated 2/7/25, to give duloxetine delayed release 90 mg via GT at bedtime for depression as manifested by refusal of care and tearfulness/ crying, with special instructions: BBW (black box warning (serious, stringent safety notice required by the US Food and Drug Administration for prescription labels, highlighting severe or life-threatening risks such as death, injury or cancer) - at risk for suicidal thinking, abnormal behavior with use of antidepressants; and - dated 6/30/25, to give valproic acid 250 mg via GT everyday at 0900 and 2100 hours, for mood stabilization as manifested by angry outbursts. a. Review of Resident 7's Informed Consent Form for duloxetine medication use showed an informed consent dated 2/25/26, was signed by the MD on 3/4/26, with no indication if the Resident 7's responsible party was informed and was not signed by the responsible party. Review of Resident 7's progress notes did not indicate if Resident 7's responsible party was notified/informed consent was obtained for duloxetine medication use. Review of Resident 7's MAR for April 2026 showed Resident 7 was administered with the duloxetine medication on 4/1 to 4/8/26. b. Review of Resident 7's medical records did not show an informed consent was initiated/completed the valproic acid medication use. Review of Resident 7's progress notes did not indicate if Resident 7's responsible party was notified/informed consent was obtained for valproic acid medication use. Review of Resident 7's MAR for April 2026 showed Resident 7 was administered with valproic acid medication twice a day on 4/1 to 4/8/26. On 4/9/26 at 953 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DSD. The DSD verified Resident 7's informed consent for duloxetine medication dated 2/25/26, was not signed by Resident 7's responsible party and there was no informed consent for valproic acid medication use. The DSD stated on admission or when we get the order, the family would be notified and will obtain informed consent before the medication is started. On 4/9/26 at 1343 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified Resident 7's informed consent for duloxetine medication dated 2/25/26, was not signed by Resident 7's responsible party and there was no informed consent for valproic acid medication use. The DON stated, the existing process of this hospital-based facility was missing this informed consent on psychotropic medication use. The DON further stated these consents should have been obtained and completed.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **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 ensure privacy was provided during care to one of 12 final sampled residents (Resident 12) and two nonsampled residents (Residents 9 and 23). * The facility failed to ensure the privacy curtains were fully closed during the medication administration to Resident 9. * The facility failed to ensure the privacy curtains were fully closed during the tracheostomy care and suctioning to Residents 12 and 23. These failures had the potential to negatively affect the dignity of the residents and violate the residents' rights to privacy.Findings: Review of the facility's P&P titled Resident Privacy and Confidentiality dated 3/2026 showed to always use curtains to provide full visual privacy when caring for the resident. 1. Medical record review for Resident 9 was initiated on 4/6/26. Resident 9 was admitted to the facility on [DATE]. Review of Resident 9's H&P examination dated 9/26/25, showed Resident 9's general status was unresponsive. On 4/7/26 at 959 hours, a medication administration observation for Resident 9 was conducted with LVN 4. LVN 4 was observed pulling Resident 9's gown to access the GT for the medication administration. When LVN 4 was about to administer Resident 9's medications via GT, LVN 4 was asked if she forgot to do something, LVN 4 stated oh my, I forgot, I was supposed to close the curtain completely. On 4/7/26 at 1056 hours, an interview was conducted with the DSD. The DSD was made aware LVN 4 failed to fully closed the privacy curtain before exposing Resident 9's abdominal area. The DSD stated the curtain should be fully closed during administration of GT medications. Review of Resident 9's ADL and Dignity Care Plan with long term goal dated 6/17/26, showed Resident 9 required total assistance in all areas of ADL and the interventions included to provide privacy and dignity. On 4/8/26 at 910 hours, another medication administration observation for Resident 9 was conducted with LVN 6. LVN 6 was observed pulling Resident 9's gown to access the GT for the medication administration. LVN 6 did not fully close the privacy curtain during Resident 9's medication administration via GT. LVN 6 stated I forgot, I should have closed it. On 4/8/26 at 1315 hours, an interview was conducted with RN 1. RN 1 made aware LVN 6 did not close the privacy curtain completely during medication administration via GT. RN 1 stated LVN 6 should have drawn the curtain completely for privacy. 2a. Medical record review for Resident 23 was initiated on 4/6/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's H&P examination dated 9/26/25, showed resident was awake and non-communicative. b. Medical record review for Resident 12 was initiated on 4/6/26. Resident 12 was admitted to the facility on [DATE]. Review of Resident 12's H&P examination dated 7/31/25, showed Resident 12 is neurologically awake but had no other meaningful response. On 4/7/26 at 1340 hours, an observation was conducted for Residents 12 and 23. RT 1 was observed from across the room suctioning Resident 23 without fully closing the privacy curtain towards roommate Resident 12's bed and the doorway. Thereafter, RT 1 went to suction Resident 12 without fully closing the privacy curtains towards the side of Resident 23. The facility staff was also observed coming in and out of the room replacing some supplies. An interview was conducted with RT 1 right after suctioning Residents 12 and 23. RT 1 acknowledged she did not fully close the privacy curtain when she suctioned Residents 12 and 23. RT 1 stated the privacy curtain was supposed to be fully closed. On 4/7/26 at 1356 hours, an observation and interview was conducted with LVN 4. LVN 4 verified and acknowledged the privacy curtains for Resident 12 and 23 were not fully closed when RT 1 was suctioning the residents. LVN 4 stated yes, we all have to remember, to close the privacy curtains during care, it is for the residents not for us. On 4/9/26 at 1343 hours, an interview was conducted with the DON. The DON was made aware and acknowledged the above findings.

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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, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary services to attain or maintain the highest practicable well-being for one of 12 final sampled residents (Resident 2). * The facility failed to ensure Resident 2's injection sites were rotated for the administration of the Lovenox (blood thinner medication) and insulin medications. This failure had the risk for lipodystrophy (buildup of fatty lumps) and decreased the medication absorption.Findings: According to Taylor's Clinical Nursing Skills seventh edition, the various sites used for subcutaneous injections (injections given in the fatty tissue, just under the skin) are the outer aspect of the upper arm, the abdomen (from below the costal margin to the iliac crest), the anterior aspect of the thigh, the upper back, and the upper ventral (front upper) or dorsogluteal area (buttocks). It is necessary to rotate sites or areas for injection to prevent buildup of fibrous tissue and permits complete absorption of the medication. Review of facility's P&P titled Insulin Administration revised date 1/2006 showed for the licensed nurses to rotate the injection sites using the upper and lateral areas, thighs, arms, abdomen and gluteal region. The P&P showed a key point for the administration of Insulin in the same site may cause atrophy (the wasting away or decrease in size of body tissues), hypertrophy (increase in size of skeletal muscle) and fibrous masses. These can be unsightly and interfere with proper absorption. Medical record review for Resident 2 was initiated on 4/7/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Patient Orders showed the following physician's orders:- dated 1/13/26, to administer Lovenox 40 mg subcutaneous daily;- dated 1/17/26, to administer insulin glargine (long-acting insulin) 32 units subcutaneously at 0600 hours; and- dated 1/17/26, to administer insulin glargine (long-acting insulin) 26 units subcutaneously at 1800 hours. Review of Resident 2's MARs for March and April 2026 showed the injection sites to administer the medications were not rotated for the following: * Resident 2 received the Lovenox at the same injection site on the following: - dated 3/17/26 at 0932 hours and 3/18/26 at 0929 hours, the Lovenox was administered at the left lower quadrant of the abdomen;- dated 3/31/26 at 0931 hours and 4/1/26 at 0926 hours, the Lovenox was administered at the left lower quadrant of the abdomen; and- dated 4/4/26 at 0841 hours and 4/5/26 at 0926 hours, the Lovenox was administered at the right lower quadrant of the abdomen * Resident 2 received insulin injection scheduled at 0600 hours at the same injection sites on the following:- dated 3/12/26 at 0607 hours and 3/13/26 at 0627 hours, 32 units of glargine insulin was administered at the left lower quadrant of the abdomen;- dated 3/22/26 at 0643 hours; 3/23/26 at 0532 hours; 3/24/26 at 0614 hours; and 3/25/26 at 0618 hours, 32 units of glargine insulin was administered at the left upper quadrant of the abdomen; and- dated 3/30/26 at 0612 hours and 3/31/26 at 0523 hours, 32 units of glargine insulin was administered at the left upper quadrant of the abdomen. * Resident 2 received insulin injection scheduled at 1800 hours at the same injection sites on the following:- dated 3/3/26 at 1838 hours and 3/4/26 at 1803 hours, 26 units of glargine insulin was administered at the right lower quadrant of the abdomen; - dated 3/31/26 at 1835 hours and 4/1/26 at 1758 hours, 26 units of glargine insulin was administered at the left lower quadrant of the abdomen;- dated 4/3/26 at 1755 hours and 4/4/26 at 1720 hours, 26 units of glargine insulin was administered at left thigh; and - dated 4/6/26 at 1756 hours and 4/7/26 at 1844 hours, 26 units of glargine insulin was administered at the left lower quadrant of the abdomen. On 4/8/26 at 1110 hours, an interview and concurrent medical record review for Resident 2 was conducted with LVN 2. LVN 2 verified she had administered the anticoagulant and insulin medication to Resident 2. LVN 2 stated she administered the medication on different sites and added it was important to rotate the injection sites so the medication will absorb faster and for the convenience of the resident. LVN 2 was asked how would she know where the last injection site was, LVN 2 stated it will show on the MAR where the last injection site was. LVN 2 was informed and verified the findings. On 4/9/26 at 0829 hours, an interview and concurrent medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review for Resident 2 was conducted with the DSD. The DSD was asked about the process for the medication administration of the anticoagulant and insulin injection medications. The DSD stated there should be a physician's order and the nurse would administer the medication as ordered and rotate the injection sites to prevent any complications. The DSD was informed of the findings. The DSD verified and acknowledged the injection sites were not rotated for the administration of anticoagulant and insulin medication. On 4/9/26 at 1501 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the necessary care and services were provided to prevent the risk and development of pressure injuries for two of 24 (Residents 2 and 20) residents in the facility. * The facility failed to ensure Resident 2's low air loss mattress setting was accurate and failed to obtain a physician's order for the low air loss mattress setting. * The facility failed to ensure Resident 20's low air loss mattress setting was accurate per the physician's order. These failures placed Residents 2 and 20 at risk for the development or worsening of pressure injuries. Findings: Review of the facility's P&P titled Pressure Ulcer Prevention, Management Protocol and Treatment revised 10/2021 showed prevention techniques for pressure injuries included providing the resident a low air loss mattress and to follow the manufacturer's recommendations for the pump settings. Review of the facility's P&P titled Low Air Loss Mattress dated 1/2026 showed the facility would provide proper placement and management of a low air loss mattress when utilized by a resident. In addition, the manufacturer's guidelines should be reviewed for each individual mattress to ensure that the policy is what is recommended. If the policy is not in agreement with the manufacturer's guidelines, the manufacturer's guidelines will be followed. Review of the Medline Supra Air Pro Low Air Loss Alternating Pressure Mattress and Pump Manual (undated) showed the Supra Air Pro mattress was suitable for pressure ulcer treatment and intended to reduce the incidence of pressure ulcers. In addition, under the operation instructions, it was recommended the air mattress's pump settings were adjusted to the patient's weight and comfort. 1. On 4/6/26 at 0920 and 1004 hours, Resident 20 was observed in his bed on a low air loss mattress. The pump for the low air loss mattress' weight setting was set at 450 lbs. On 4/7/26 at 0942 and 1309 hours, Resident 20 was observed in his bed on a low air loss mattress. The pump for the low air loss mattress' weight setting was set at 450 lbs. Medical record review for Resident 20 was initiated on 4/6/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 9/19/25, showed Resident 20 had a diagnosis of severe traumatic brain injury. Review of Resident 20's Patient Orders showed a physician's order dated 2/25/26, for a low air loss mattress for wound healing. Review of Resident 20's MDS assessment dated [DATE], under Section B, showed Resident 20 was at a persistent vegetative state and had no discernible consciousness. Review of Resident 20's Skin assessment dated [DATE], showed Resident 20 had a Stage 4 pressure injury (full thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) located at his sacrum. Review of Resident 20's Body Measurements dated 4/2/26, showed Resident 20 weighed 125.4 lbs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 20's Braden Scale Assessment (evidence based tool for assessing a resident's risk of developing pressure injuries) dated 4/7/26, showed the following:- for sensory, Resident 20 was documented as very limited, they respond only to painful stimuli or had a sensory impairment which limited their ability to feel pain or discomfort over half of their body;- for activity, Resident 20 was documented as bedfast;- for mobility, Resident 20 was documented as completely immobile; and - Resident 20 had a score of 12, which indicated Resident 20 was at risk for pressure injuries. On 4/7/26 at 1326 hours, an observation and concurrent interview for Resident 20 was conducted with LVN 5. LVN 5 stated Resident 20 was provided with a low air loss mattress for wound healing due to his Stage 4 pressure injury. LVN 5 stated the low air loss mattress settings were adjusted to the resident's weight. LVN 5 stated Resident 20 weighed around 130 lbs. LVN 5 verified Resident 20's low air loss mattress settings were set at 450 lbs. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON stated the low air loss mattress pump settings should be based on the resident's weight. The DON was informed and acknowledged the above findings. 2. On 4/6/2026 at 0859 hours and 4/7/26 at 0825 hours, Resident 2 was observed in bed asleep. Resident 2's low air loss mattress was observed on the maximum level of weight 450 lbs. setting on the machine. Medical record review for Resident 2 was initiated on 4/6/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Patient Orders showed a physician's order dated 2/5/26, to place resident on an air mattress. However, further review of the physician's order failed to show documented evidence for a specific order for the low air loss mattress setting was obtained. On 4/7/2026 at 1436 hours, an observation and concurrent interview for Resident 2 was conducted with LVN 3. LVN 3 verified and acknowledged Resident 2's use of the low air loss mattress. LVN 3 was asked about the low air loss mattress setting on the machine. LVN 3 verified the setting was at the maximum level as observed. LVN 3 stated the setting should be based on the resident's weight and a physician's order. LVN 3 was asked about the physician's order for the low air loss mattress. LVN 3 verified the physician's order; however, when asked if there was a specific instruction about the setting of the low air loss mattress machine, LVN 3 acknowledged and verified there was no specific physician's order for the setting of the machine. On 4/9/2026 at 1501 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and medical record review, the facility failed to provide the appropriate restorative care and services for one of 12 final sampled residents (Resident 24). * The facility failed to provide a left soft hand roll to Resident 24 as per the physician's orders. This failure posed a risk for Resident 24 to have decreased range of motion and mobility.Findings: On 4/6/26 at 0940 hours, 4/7/26 at 0933 hours, and 4/9/26 0801 hours, Resident 24 was observed lying in bed wearing a PRAFO on her left ankle and a splint on her right hand. Resident 24's left hand was in a fist position. Medical record review for Resident 24 was initiated on 4/6/26. Resident 24 was admitted to the facility on [DATE]. Review of Resident 24's MDS assessment dated [DATE], showed Resident 24's cognitive skills for daily decision making were severely impaired. Resident 24 had diagnoses such as cerebral palsy (a disorder that affected a person's movement and posture), quadriplegia (paralysis affecting all four limbs), and contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion). Review of Resident 24's Patient Orders showed the following physician's orders:- dated 5/22/23, RNA to provide the resident gentle PROM to all four extremities daily;- dated 5/22/23, to apply left soft hand roll at all times and could be removed for ADLs;- dated 3/31/26, to apply a PRAFO to the left ankle for four hours as tolerated after ADLs. In addition, to check every two hours for proper positioning and skin redness; and- dated 3/31/26, to apply right soft hand roll the rest of the time and could be removed for ADLs. Review of Resident 24's Care Plan showed a care plan problem dated 3/10/09, for ADLs functional status/rehabilitation potential. The interventions included to allow extra time for the resident to complete the ADLs, explain all procedures and purpose of treatment care such as the application of the PRAFO to Resident 24's left ankle for four hours or as tolerated, applying left and right soft hand rolls at all times, applying a right hand/wrist splint daily for four hours, and providing gentle PROM to all four extremities daily. Review of Resident 24's PT Reevaluation assessment dated [DATE], showed Resident 24 had bilateral upper and bilateral lower contractures and flaccid muscle tone. In addition, the assessment showed Resident 24 kept their first digit (thumb) of their left hand adducted (movement towards the middle of the body) and flexed to the palm of their hand. On 4/9/26 at 1040 hours, an interview and concurrent medical record review for Resident 24 was conducted with RNA 1. RNA 1 stated Resident 24 received daily RNA services which included wearing a left ankle PRAFO, right hand splint, a right soft hand roll, and passive range of motion to all four extremities. RNA 1 stated a soft hand roll was an item the resident could hold such as a rolled-up towel for positioning. RNA 1 further stated the RNAs were expected to document the RNA services provided to Resident 24 in the RNA flowsheet.Review of Resident 24's RNA Flowsheet for April 2026 was reviewed with RNA 1. The flowsheet showed the following interventions were implemented:- PRAFO to the left ankle was applied from 4/1 to 4/7/26, and 4/9/26;- right soft hand roll was applied from 4/1 to 4/7/26, and 4/9/26;- right hand/wrist splint was applied from 4/1 to 4/7/26, and 4/9/26; and- gentle PROM to all four extremities from 4/1 to 4/7/26, and 4/9/26. Further review of Resident 24's RNA Flowsheet for April 2026 failed to show documentation if the left soft hand roll was provided to Resident 24. When RNA 1 was asked if Resident 24 was provided with a soft hand roll to her left hand, RNA 1 stated no, because there was no order to provide the service. On 4/9/26 at 1110 hours, an observation, interview, and concurrent medical record review for Resident 24 was conducted with LVN 12. LVN 12 reviewed Resident 24's physician orders and verified Resident 24 had an order dated 5/22/23, to apply left soft hand roll at all times and could be removed for ADLs. Resident 24 was observed lying in bed with a PRAFO on her left ankle, a splint on her right hand and right soft hand roll. Resident 24's left hand was observed in a fist position. LVN 12 verified Resident 24 was not provided with a left soft hand roll per the physician's orders. On 4/9/26 at 1323 hours, an interview was conducted with the DSD. The DSD stated the charge nurse's responsibility (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was to update the RNA's flowsheet binder monthly to ensure the residents were provided with the appropriate RNA services. The DSD further stated the RNAs were expected to follow the orders provided within the RNA flowsheets, such as applying splint devices. On 4/9/26 at 1402 hours, an interview for Resident 24 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services to prevent accidents for one of 12 final sampled residents (Resident 4). * The facility failed to ensure Resident 4's upper side rail pads were in place as per physician's order for safety/seizure precautions. This failure had the potential to put the resident at risk for serious injuries.Findings: Review of the facility's P&P tilted Seizure Precaution dated 4/2026 showed the facility ensure the safety of residents who had diagnosis of seizures by providing side rails padded with anti-trauma pads. On 4/6/26 at 1117 hours and 4/7/26 at 0801 hours, Resident 4 was observed in bed with both upper side rails elevated and no pads were in place. Medical record review for Resident 4 was initiated on 4/6/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed Resident 4 had moderate cognitive impairment and a diagnosis of seizure disorder. Review of Resident 4's Resident Orders dated 4/7/26, showed the following physician's order:- dated 3/25/24, to monitor seizure episodes every shift and tally with hashmarks; and- dated 3/16/26, to place bilateral padded upper side rails for safety/seizure precautions. Review of Resident 4's Treatment Flowsheet for the month of April 2026 showed the bilateral upper side rail padded for safety/seizure precaution was implemented. On 4/8/26 at 0806 hours, an observation and concurrent interview was conducted with LVN 1 at Resident 4's bedside. LVN 1 verified Resident 4 had elevated bilateral upper side rails but there were no pad in placed. LVN 1 verified there was a monitoring log for the use of the side rail. LVN 1 stated the order for the padding of the side rail was discontinued; however, when asked if the side rail was discontinued, LVN was uncertain and unable to answer. LVN 1 verified there was no pad on both upper side rail. LVN 1 further stated the Resident 4's bed was changed yesterday and they forgot to replace the side rails padding. LVN 1 verified Resident 4 had a seizure diagnosis and with a physician's order for the bilateral upper side rails with pad for seizure precaution. LVN 1 acknowledged Resident 4 should have padded side rails at all times when in bed for seizure precaution. On 4/8/26 at 0858 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 1. RN 1 stated a physician's order for a bilateral upper side rail with pad must be obtained for the resident who have a seizure diagnosis. RN 1 verified Resident 4 had a seizure diagnosis and a physician's order for the side rails with the pad for seizure precaution. RN 1 was informed of the above observation and acknowledged Resident 4 should have padded side rails at all times when in bed for seizure precaution. On 4/09/2026 at 1501 hours, an interview and concurrent medical record review for Resident 4 was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services for the use of an indwelling urinary catheter for one of three final sampled residents (Resident 3) reviewed for indwelling urinary catheter care. * The facility failed to ensure Resident 3's indwelling urinary catheter had no sediments in the tubing. In addition, the facility failed to notify the clinician when Resident 3 had sediments in the indwelling urinary catheter. These failures had the potential for Resident 3 to develop complications associated with the use of indwelling urinary catheter.Findings: Review of the facility's P&P titled Urinary Catheter Management revised 11/2020 showed guidelines for the residents with indwelling urinary catheters that included to observe urinary drainage for cloudiness, odor, mucus, blood or sediment, and to report any abnormal findings. On 4/7/26 at 1308 hours, Resident 3 was observed to have an indwelling urinary catheter connected to a urinary drainage bag placed at the left side of the bed. The indwelling urinary catheter was observed to have a lot of sediments in the tubing. The urinary drainage bag was dated 4/1/26. Medical record review for Resident 3 was initiated on 4/6/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3's cognitive skills for daily decision making were severely impaired. In addition, the assessment showed Resident 3's use of an indwelling urinary catheter and had Stage 4 pressure ulcer. Review of Resident 3's Patient Orders showed the following physician's orders:- dated 10/12/25, to provide indwelling urinary catheter care;- dated 1/29/26, to irrigate the bladder with 100 ml of sterile water through the urinary catheter every twelve hours, discontinued on 2/25/26; and- dated 3/18/26, to maintain an existing indwelling urinary catheter for incontinence and perineal wounds. In addition, to change if clogged or leaking. Review of Resident 3's Care Plan showed the following care plan problem: - dated 1/29/26, for Resident 3's sediments in urine. The interventions included to monitor Resident 3's urine daily for sediments and to change the foley once a month or as needed; and - dated 3/9/26, for Resident 3's alteration in urinary function. The interventions included to monitor the character of urine output such as color, odor, amount, and consistency and to report abnormal findings to the MD. Review of Resident 3's Genitourinary assessments showed Resident 3's urine appearance was documented to have had sediments in the urine on the following dates and times:- dated 3/28/26 at 0852 hours;- dated 3/30/26 at 2226 hours;- dated 4/1/26 at 2050 hours;- dated 4/3/26 at 2305 hours, in addition, urine appearance was documented as cloudy; and- dated 4/4/26 at 2036 hours, in addition, urine appearance was documented as cloudy. Further review of Resident 3's medical record failed to show documented evidence if the clinician was notified regarding Resident 3's urine output characteristics. On 4/7/26 at 1509 hours, an observation and concurrent interview for Resident 3 was conducted with LVN 6. LVN 6 was asked about the indwelling urinary catheter care for Resident 3. LVN 6 verified the indwelling urinary catheter tubing had whitish color streaks, and the urinary drainage bag had brown sediments.On 4/7/26 at 1521 hours, an interview was conducted with the DON. The DON stated if the sediments were observed in a resident's indwelling urinary foley catheter tubing, the licensed nursing staff should notify the clinician for further orders.On 4/7/26 at 1545 hours, an observation, and concurrent follow up interview and medical record review for Resident 3 was conducted with the DON. The DON verified the indwelling urinary catheter tubing had whitish color streaks, and the urinary drainage bag had brown sediments. The DON stated Resident 3 had sediments in her urine in January 2026 and was provided bladder irrigation until the order was discontinued by the clinician in February 2026 due to no signs of infection. When asked if the clinician was notified regarding Resident 3's current urinary characteristics, the DON was unable to provide documented evidence in Resident 3's medical record. The DON further stated the clinician should have been notified of Resident 3's sediments in her urine.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **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 appropriate care and services for the use of the GT (Gastrostomy Tube) for two of 21 residents (Residents 3 and 20) with GT feedings. * The facility failed to ensure Resident 3's GT extension feeding tube was disconnected after their tube feeding formula was completed. * The facility failed to ensure Resident 20's GT extension feeding tube was disconnected after their tube feeding formula was completed. These failures posed the risk of tube clogging, leaking, not functioning properly, and for developing bacterial growth (infection) for Residents 3 and 20.Findings: Review of the facility's P&P titled Enteral Feeding revised 12/2020 showed to review the order for feedings such as formula, dose limit, rate, and number of hours for infusion per physician orders. In addition, to check the GT placement by auscultating air and to check feeding residual by aspirating stomach content. Lastly, to discontinue the tube feeding when volume dose limit was reached. 1. On 4/8/26 at 0522 hours, Resident 20 was observed asleep with the head of the bed elevated. Resident 20 was observed connected to a GT extension tubing with Vital AF 1.2 formula (enteral nutrition formula designed to manage inflammation and support gastrointestinal tolerance) dated 4/7/26 at 7 PM; the enteral pump was off. Medical record review for Resident 20 was initiated on 4/6/26. Resident 20 was admitted to the facility on [DATE]. Review of Resident 20's H&P examination dated 9/19/25, showed Resident 20 had a diagnosis of severe traumatic brain injury and was a GT dependent. Review of Resident 20's Plan of Care showed a care plan problem dated 10/1/25, addressing Resident 20's GT feeding due to swallowing issues related to his tracheostomy status. The interventions included to change the feeding tubing per facility protocol and to check the feeding tube placement and residual prior to giving medication and feedings. Review of Resident 20's Patient Orders showed the following physician's orders:- dated 2/17/26, to administer Vital AF 1.2 formula via PEG tube at 90 ml/hr daily, to provide a total of 1800 ml/2160 kcals to administer via enteral pump via GT, and to start the tube feeding infusion at 0600 hours until total dose was completed. Review of Resident 20's MDS assessment dated [DATE], under Section B, showed Resident 20 was at a persistent vegetative state and had no discernible consciousness. On 4/8/26 at 0537 hours, an interview and concurrent observation for Resident 20 was conducted with LVN 7. LVN 7 was observed donning a gown and gloves prior to entering Resident 20's room. LVN 7 stated Resident 20's enteral feedings were administered at 0600 hours daily and was infused for 20 hours. LVN 7 stated Resident 20's GT feeding completed at 0400 hours. When asked if the GT extension tubing should be disconnected after each dose was completed, LVN 7 stated no. LVN 7 then turned on the GT enteral pump and began to administer the GT formula. On 4/8/26 at 0604 hours, an interview was conducted with RN 2. RN 2 stated when the resident reached the GT formula dose limit, the licensed staff members were expected to turn off the enteral pump and disconnect the resident from the GT extension tubing. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON stated when the resident reached the GT formula dose limit, the licensed staff members were expected to clear the settings of the enteral pump, then disconnect the resident from the GT extension tubing. The DON was informed and acknowledged the above findings. 2. On 4/8/26 at 0537 hours, Resident 3 was observed in bed with the head of the bed elevated. Resident 3 was observed connected to a GT extension tubing with Vital AF 1.2 formula dated 4/7/26 at 2000 hours, and a water bag dated 4/7/26 at 0600 hours; the enteral pump was off. Medical record review for Resident 3 was initiated on 4/6/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 5/31/25, showed Resident 3 had a GT. Review of Resident 3's MDS assessment dated [DATE], under Section C, showed Resident 3's cognitive skills for daily decision making was severely impaired. Review of Resident 3's Patient Orders showed the following physician's orders:- dated 3/17/26, to administer (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vital AF 1.2 formula via GT at 70 ml/hr, to provide a total of 1400 ml/1680 kcals to administer via enteral pump via GT, and to start the tube feeding infusion at 0600 hours until total dose was completed. Review of Resident 3's Plan of Care showed a care plan problem dated 6/11/25, addressing Resident 3's potential for nutritional deficit. The interventions included to change the feeding tubing per facility protocol and to check the feeding tube placement and residual prior to giving medication and feeding. On 4/8/26 at 0540 hours, an interview and concurrent observation for Resident 3 was conducted with LVN 8. LVN 8 was observed donning a gown and gloves prior to entering Resident 3's room. LVN 8 stated Resident 3 completed her GT formula at 0300 hours. LVN 8 further stated that when GT feedings reached the dose limit, the licensed staff members would turn off the machine and keep the residents connected to the GT extension tubing until the next scheduled feeding. On 4/8/26 at 0604 hours, an interview was conducted with RN 2. RN 2 stated when the resident reached the GT formula dose limit, the licensed staff members were expected to turn off the enteral pump and disconnect the resident from the GT extension tubing. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON stated when the resident reached the GT formula dose limit, the licensed staff members were expected to clear the settings of the enteral pump, then disconnect the resident from the GT extension tubing. 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 interview, medical record review, and facility P&P review, the facility failed to ensure appropriate pain management was provided for one of five final sampled residents (Resident 3) reviewed for unnecessary medications. * The facility failed to assess Resident 3's pain prior to the administration of morphine (pain medication). In addition, the facility failed to reassess Resident 3's pain after the administration of morphine. These failures had the potential to put the resident at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medication.Findings: Review of the facility's P&P titled Pain Management Plan dated 1/2002 showed the purpose of the pain management plan was to provide guidelines for the appropriate assessment and management of pain for all the residents. If a resident was unable to self-report the pain scale from 0-10 using the [NAME] scale, the Objective Pain Scale for Cognitively or Communicatively Impaired Adults and Children More than Three Years of Age would be utilized. All the residents will be monitored for pain before and after pain relieving interventions. The pain scale should be documented as the fifth vital sign when vital signs are obtained by the licensed nurse every shift. A reassessment evaluation will include documentation of the response to the pain interventions, side effects of the treatment and risk factors for adverse events caused by the treatment. Medical record review for Resident 3 was initiated on 4/6/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's plan of care showed a care plan problem for Resident 3's morphine pain medication dated 9/9/25. The interventions included to monitor for black box warning adverse reactions, to notify the MD as necessary and to monitor vital signs every shift and as needed. Review of Resident 3's Patient Orders showed the following physician's orders:- dated 5/31/25, to monitor Resident 3's pain every shift; - dated 11/18/25, to administer morphine 5 mg of 10 mg /5 ml solution via GT every six hours as needed for breakthrough pain;- dated 1/30/26, to administer morphine 10 mg /5 ml solution via GT every 12 hours for pain management; and- dated 3/9/26, to administer acetaminophen (pain medication) 650 mg tablet via GT every four hours as needed for mild pain (1-3 of 10; on the pain scale of 0 to 10 with 0 = no pain and 10 = worst). Review of Resident 3's MDS assessment dated [DATE], showed Resident 3's cognitive skills for daily decision making were severely impaired. In addition, Resident 3 had a Stage 4 pressure ulcer. Review of Resident 3's MAR for March and April 2026 showed the following: - morphine 5 mg was administered on 3/27/26 at 1641 hours for signs and symptoms of pain manifested by facial grimacing and moaning; - morphine 10 mg was administered twice a day from 3/1 to 4/7/26. Review of Resident 3's pain scale summary showed the following entries for March and April 2026: - dated 3/18/26 at 1455 hours, a pre-treatment assessment that utilized the FLACC pain scale (a behavioral assessment tool designed to measure pain in infants, young children two months to seven years, and nonverbal individuals who cannot self report) with a pain level score of 0. A post-treatment assessment was documented with a pain score level of 0.- dated 3/30/26 at 1050 hours, a pre-treatment assessment that utilized the numerical pain scale, showed a pain level of 0. A post-treatment assessment was documented with a pain score level of 0.- dated 4/7/26 at 1440 hours, a pre-treatment assessment that utilized the FLACC pain scale with a pain level score of 1. A post-treatment assessment was documented with a pain score level of 1.However, further review of Resident 3's medical record failed to show documentation of pain assessments or reassessments on other dates and times following the administration of the morphine medication. On 4/8/26 at 1028 hours, an interview and concurrent medical record review for Resident 3 was conducted with LVN 6. LVN 6 stated the process for pain management included to assess the resident's behavior for pain, check the resident's physician's orders, provide non-pharmacological interventions such as repositioning, provide a pain medication as needed, then to reassess the resident after the pain management intervention. When LVN 6 was asked where Resident 3's pain assessments were documented, LVN 6 stated on the resident's MAR or on the vitals signs section. (continued on next page)

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	555709	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chapman Global Medical Center D/P Snf	2601 East Chapman Avenue Orange, CA 92869

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 6 reviewed Resident 3's medical record and verified there was no documented evidence Resident 3 was consistently assessed for pain. On 4/8/26 at 1503 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. RN 1 reviewed Resident 3's MAR for 4/2026 and verified there was no documented evidence Resident 3 was assessed for pain. On 4/9/26 at 1402 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated she expected the licensed staff members to monitor the residents' pain every shift and reassess their pain after an hour of pain medication administration, especially for the residents who received narcotic medications routinely or as needed. The DON verified there was no documented evidence Resident 3 was consistently assessed for pain. The DON was informed and acknowledged the above findings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary pharmaceutical services to two of 12 final sampled residents (Residents 2 and 7). * The facility failed to monitor for adverse effects for Resident 2's anticoagulant medication and failed to obtain a physician's order to monitor the anticoagulant medication use. * There was no evidence nonpharmacological interventions were ordered, performed and documented for Resident 7's use of psychoactive medications. These failures had the potential to result in unnecessary use of, ineffective and/or lack of monitoring or interventions for psychotropic and anticoagulant medications that could negatively affect the residents highest practicable mental, physical, and psychosocial well-being.Findings: 1. Review of the facility's P&P titled Psychoactive Medications/ Chemical Restraint dated 3/2026 showed residents will receive psychoactive medications only when they are necessary to treat medical, mood, behavioral or psychiatric symptoms. These medications will not be used for discipline or for the convenience of the team members. The assessment process is utilized using the following: For anti- psychotic medications: - clinical symptomology/diagnosis warranting chemical interventions; - environmental causes of residents' distress/behavior have been ruled out; - alternative interventions/behavioral management programs have been attempted; - the drug regimen is free from unnecessary drugs; - behavioral management programs are a continuing part of the plan of care; - documentation has been done to identify early concerns, evaluations, interventions and response to treatments; and - physician has been provided with summaries of resident's behavioral manifestations, response to behavioral programs and medications. For anti-depressant medications: - provide therapeutic interventions for residents with depression e.g. withdrawal behavior, refusal to speak, poor appetite, and loss of interest, prior to the initiation of any drug therapy; - psychiatric consultation for the use of any antidepressant medication outside the DSM IV guidelines to justify the medication is clinically appropriate; and - do not use behavioral monitoring charts unless specifically ordered by the physician. Medical record review for Resident 7 was initiated on 4/6/26. Resident 7 was admitted to the facility on [DATE]. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 7's care plan for behavioral symptoms of depression dated 11/17/20, showed nonpharmacological approaches as part of the interventions to minimize the depressed symptoms. However, there was no documentation to show the nonpharmacological approaches were being done and monitored. Review of Resident 7's Patient Orders showed the following orders: - dated 2/7/25, duloxetine (antidepressant) delayed release 90 mg via GT daily, for depression manifested by refusal of care and tearfulness/crying; and - dated 6/30/25, valproic acid (anticonvulsant) syrup 250 mg via GT daily, for mood stabilization manifested by angry outbursts. Review of Resident 7's care plan for use of valproic acid for mood stabilization dated 6/30/25, failed to show interventions for having nonpharmacological interventions. Review of the Pharmacist Drug Regimen Review for January to March 2026 did not show recommendations specific to the use of the valproic acid and duloxetine medications. Review of Resident 7's MDS assessment dated [DATE], showed a BIMS score of 99, meaning the resident was unable to complete the interview. Review of Resident 7's medical record failed to show documented evidence nonpharmacological interventions were ordered, provided or documented for the duloxetine and valproic acid medications. On 4/9/26 at 0953 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DSD. The DSD verified there was no documented evidence to show nonpharmacological interventions were ordered, provided or documented for the duloxetine and valproic acid medications. The DSD stated the DON and IDT review these medications. On 4/9/26 at 1208 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON verified Resident 7 did not have nonpharmacological interventions for the use of the valproic and duloxetine medications. 2. Review of the facility's P&P titled High Alert Medication Management revised date 9/2023 showed the facility shall develop and maintain a list of high alert medications which require specific measures and safeguards to reduce the risk of errors related to the ordering and prescribing, transcribing, preparation, storage, distribution, and administration of these medications. High alert medications have inherent increased risks of causing significant harm to patients when used in error. High alert medications included anticoagulants and will be monitored daily to look for any signs of unusual bleed or other adverse reactions that may have occurred. Medical record review for Resident 2 was initiated on 4/6/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's Patient Orders showed a physician's order dated 1/13/26, to administer Lovenox (anticoagulant medication) 40 mg subcutaneous (under the skin) daily. However, further review of the physician's order failed to show documented evidence a physician's order was obtained for the monitoring of the adverse reaction for the use of anticoagulant medication. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 2's medical record failed to show documented evidence for the monitoring of adverse reaction of anticoagulant medication use. Review of Resident 2's care plan for the Lovenox medication dated 1/22/26, showed interventions including to monitor for symptoms of bleeding and to notify the physician when symptoms develops such as bleeding. On 4/9/26 at 0829 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DSD. The DSD verified Resident 2's use of anticoagulant medication and stated there should have been a physician's order and the nurse should administer the medication as ordered. The DSD stated adverse reactions such as bleeding should be monitored. The DSD was asked if there was any documentation on the medical records for the monitoring of the adverse reaction such as bleeding for Resident 2. The DSD stated the licensed nurses usually document in the nurses progress for the monitoring of the adverse reaction of anticoagulant medication. The DSD failed to show documentation of the monitoring of the adverse reaction of anticoagulant medication. The DSD verified there was no physician's order for monitoring of adverse reaction for the use of anticoagulant medication. On 4/09/2026 at 1501 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. The DON was informed and verified the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record was accurate for one of 12 final sampled residents (Resident 3). * The facility failed to ensure the physician's orders for Resident 3's code status was accurate. Resident 3's code status showed full code status; however, Resident 3's POLST showed she was a DNR status. In addition, the facility failed to ensure the physician's order for precautions for Resident 3 was accurate. A contact precaution was ordered; however, Resident 3 no longer needed contact precautions. These failures had the potential for the residents' care needs not met as the medical record was inaccurate.Findings: Medical record review for Resident 3 was initiated on 4/6/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's Patient Orders showed the following physician's orders:- dated 5/30/25, for a full code status;- dated 1/24/26, for an enhanced barrier precaution for C. Auris; and- dated 2/1/26, for contact isolation precaution due to C. Difficile and C. Auris. a. Review of Resident 3's POLST form dated 3/31/26, under Section A, showed Resident 3 had a DNR status to allow a natural death. The POLST form further showed the form was signed by the physician and resident's legal decision maker. Review of Resident 3's Care Plan showed a care plan problem initiated on 6/11/25, addressing Resident 3's full code status. The care plan interventions included to inform the family the order had been placed on the resident's chart and respect the family decision. On 4/8/26 at 1503 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 1. RN 1 verified Resident 3's physician's orders and stated Resident 3 had a DNR status and the physician's order should reflect her current code status. On 4/9/26 at 1402 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. b. On 4/7/27 at 0950 and 1308 hours, an observation was conducted outside of Resident 3's room. An EBP signage was posted on Resident 3's room door. On 4/7/26 at 1509 hours, an observation and concurrent interview and medical record review for Resident 3 was conducted with LVN 6. An observation was conducted outside of Resident 3's room. An EBP signage was posted on Resident 3's room door. LVN 6 stated Resident 3 had EBP due to her pressure injury, GT feeding, and indwelling urinary foley catheter. When asked if Resident 3 currently had active C. Difficile, LVN 6 stated no. LVN 6 stated she would follow up with the DON regarding Resident 3's precautions. On 4/7/26 at 1521 hours, an interview and concurrent medical record review for Resident 3 was conducted with the DON. The DON stated Resident 3 did not have an active C. Difficile and the physician's order should have been discontinued to reflect Resident 3's current precautions.