STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555753	A. Building B. Wing	04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge Children's Hospital - Orange D/P Snf	393 S Tustin St Orange, CA 92866

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, document 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 three final sampled residents (Residents 19 and 23) reviewed for pressure injuries. * The facility failed to ensure Resident 19's low air loss mattress setting was accurate and on alternate mode setting. * The facility failed to ensure Resident 23's low air loss mattress settings were accurate and failed to obtain a physician's order specifying the low air loss mattress setting. These failures placed Residents 19 and 23 at risk for the development or worsening of pressure injuries and to not benefit from the therapy provided by the LAL mattress.Findings: Review of the facility's P&P titled Use of Low Air Loss Mattresses revised 11/2022 showed to provide guidelines for the safe and appropriate use of low air loss mattresses to prevent and treat pressure injuries, promote skin integrity, and enhance patient comfort in the acute care setting. These devices shall be used in accordance with physician orders, manufacturer guidelines, and clinical assessment to ensure patient safety and optimal therapeutic outcomes. A physician's order is required for the initiation of the low air loss mattress use. The order must specify the type of mattress/support surface, clinical indication and duration of use. Nursing staff should verify the physician order, inspect the mattress for proper function, ensure correct installation per manufacturer guidelines and set appropriate pressure settings based on patient weight and condition. Review of the Adapt Pro Elite Low Air Loss Alternating Pressure Mattress Manual (undated) showed the Adapt Pro Elite mattress was intended to help and reduce pressure sores while optimizing patient's comfort. The Adapt Pro Elite may be used in a variety of settings including but not limited to individual home care setting as prescribed by the physician. 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 4/27/2026 at 1011 hours, Resident 23 was observed in bed on a low air loss mattress. The low air loss mattress machine pump setting was set at a 400 lbs – firm. Medical record review for Resident 23 was initiated on 4/27/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Order Summary Report dated 4/28/26, showed a physician's order dated 4/20/26, to use a low air loss mattress every shift for skin breakdown prevention. However, further review of the Order Summary Report failed to show a physician's order specifying the setting for the low air loss mattress. On 4/28/26 at 0838 hours, an observation, interview and concurrent medical record review for (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 23 was conducted with RN 2. RN 2 verified Resident 23's use of the low air loss mattress. When asked about the low air loss mattress setting on the machine, RN 2 verified the low air loss machine setting was set at firm (firmest level) based on the light indicator on the machine. RN 2 was asked if there was a physician's order for the setting of the low air loss mattress to be set at the firm setting, RN 2 stated she was unsure and would review resident's medical record. RN 2 verified the physician's order addressed only the use of the low air loss mattress and did not include specific instructions for the mattress settings. On 4/29/26 at 1204 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 verified Resident 23's use of the low air loss mattress and the physician's order. RN 1 stated the licensed nurses adjusted the low air loss mattress setting based on the resident's weight. RN 1 verified there was no physician's order specifying the setting for the mattress. On 4/30/26 at 1416 hours, an interview and concurrent medical record review for Resident 23 was conducted with the ADON. The ADON was informed and verified the above findings. Cross Reference to F0657, example # 3. 2. On 4/27/26 at 1136 hours, during the initial tour of the facility, Resident 19 was observed lying on his back on a LAL mattress (Adapt Pro Elite) set to alternate mode with a weight setting of 110 pounds. Medical record review for Resident 19 was initiated on 4/27/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 12/16/25, showed Resident 19 had a diagnosis of anoxic brain injury and no decision-making capacity. Review of Resident 19's Quarterly MDS assessment dated [DATE], showed Resident 19 required total assistance from staff for all ADL care. Review of Resident 19's plan of care showed a care plan problem dated 12/26/25, addressing the resident's potential for pressure ulcer development related to immobility. The interventions included the resident to have LAL mattress. Review of Resident 19's Order Summary Report for 4/2026, showed the following physician's orders: - dated 12/16/25, for air mattress. - dated 4/29/26, for low air loss mattress every shift for skin breakdown prevention. Set pressure settings according to weight. Adjust pressure settings to Static while providing care and set back to Alternating setting when done. On 4/28/26 at 1210 hours, an observation and concurrent interview was conducted with RN 6 for Resident 19. Resident 19 was observed lying on a LAL mattress (Adapt Pro Elite) set to static mode with a weight setting of 110 pounds. RN 6 verified the above findings, and stated she was not familiar of different the setting types for the LAL mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/29/26 at 1613 hours, an interview and concurrent medical record review was conducted with RN 5. RN 5 was informed of the findings and stated the LAL mattress should have been on alternate mode setting when care was not being provided and switched to static mode setting only when care was provided. In addition, RN 5 stated the LAL mattress prevented the development of pressure injuries and the wrong setting could compromised the resident's skin integrity. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **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 appropriate care and services were provided for six of 19 residents (Residents 1, 6,10, 11, 17, and 22) receiving enteral feeding. * LVN 3 failed to verify GT placement prior to administering medications for Residents 1 and 17. * RN 3 failed to verify GT placement prior to administering medications for Resident 6. * LVN 4 failed to verify GT placement prior to administering medications for Resident 10. * The facility failed to ensure Resident 11's HOB (head of bed) was elevated to a minimum of 30 degrees during NGT feeding. * The facility failed to ensure Resident 22's HOB was elevated to a minimum of 30 degrees during the GT feeding. In addition, LVN 3 did not verify the GT placement prior to administering medications through the tube. These failures posed the risk for aspiration due to the improper feeding tube care.Findings: Review of the facility's P&P titled Enteral Tube Feeding via Continuous Pump dated 3/2022 showed steps in the procedure included to position the head of the bed at 30 to 45 degrees for feeding, unless medically contraindicated and to verify placement of the tube. Review of the facility's P&P titled Medication Administration; oral; IM; SQ; ID; Metered Dose; NGT; GT; JT; Vaginal, Urethral; Suppository; Eye & Ear Drops revised 4/2022 showed the procedure for administering medications via NGT and GT included to elevate the head of the bed, confirm placement of the tube by aspiration contents and/or injecting 20 ml of air; aspiration would result if tube was not in the stomach. 1. Medical record review for Resident 22 was initiated on 4/27/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's MDS assessment dated [DATE], showed Resident 22 used a feeding tube. Review of Resident 22's Care Plan Report showed the following plan of care: - revised 9/23/22, a care plan problem addressing Resident 22's risk for aspiration. The interventions included to monitor signs and symptoms of aspiration, to keep the head of the bed elevated during feeds, and follow orders for feeds and flushes. - revised 8/18/23, a care plan problem addressing Resident 22's alteration in gastrointestinal status related to her NPO status and enteral feeding dependency. The interventions included elevating the head of bed during and thirty minutes after tube feeding and checking for tube placement and gastric contents / residual volume per facility protocol. Review of Resident 22's Order Summary Report showed the following physician's orders: - dated 7/14/23, to elevate the head of bed to 30 degrees during feeds and for 30 minutes following every day shift for aspiration precautions; and - dated 7/27/25, to administer IsoSource 1.5 (enteral feeding formula) at 195 ml via GT for one hour followed by 300 ml of water to run over one hour three times a day. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. On 4/27/26 at 1004 hours, Resident 22 was observed in bed receiving Isosource 1.5 formula (enteral feeding) at 195 ml an hour. Resident 22's HOB was elevated to 15 degrees. On 4/27/26 at 1018 hours, an observation and concurrent interview for Resident 22 was conducted with LVN 1. LVN 1 verified Resident 22's HOB was not elevated to 30 degrees while receiving enteral nutrition. On 4/29/26 at 1538 hours, an interview was conducted with RN 1. RN 1 stated when the residents were receiving enteral feedings, the HOB should be elevated at least 30 degrees to prevent aspiration. b. On 4/28/26 at 0612 hours, during the medication administration observation with LVN 3, LVN 3 was observed connecting the enteral syringe to Resident 22's GT. LVN 3 was observed administering multiple medications and water through the resident's GT but did not verify the GT placement by aspirating gastric contents or injecting 20 ml of air prior to administering the medications and water. 2. On 4/27/26 at 0946 and 1557 hours, and on 4/29/26 at 0914 hours, Resident 11 was observed in a crib bed and receiving Compleat 1.0 (enteral formula) at 38 ml an hour via NGT. Resident 11's HOB was observed flat. Medical record review for Resident 11 was initiated on 4/27/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11 used a feeding tube. Review of Resident 11's Order Summary Report showed the following physician's orders: - dated 3/31/22, a nothing by mouth (NPO) diet, and - dated 3/26/26, to administer Compleat 1.0 at 38 ml an hour via NGT continuously. Review of Resident 11's Care Plan Report showed a plan of care revised 1/22/24, addressing Resident 11's tube feeding use and altered nutritional status related to dysphagia. The interventions included elevating the HOB to 45 degrees due to Resident 11's continuous feeding. On 4/27/26 at 0955 hours, an interview and concurrent observation of Resident 11 was conducted with LVN 1. LVN 1 verified Resident 11's HOB was flat while Resident 11 was receiving the enteral feeding. LVN 1 stated Resident 11 frequently slid down in bed when the HOB was elevated. LVN 1 stated the facility staff members were aware of Resident 11's positioning during enteral feeding and stated keeping Resident 11's HOB at a flat position was the best they could do. On 4/29/26 at 0929 hours, an interview and concurrent observation for Resident 11 was conducted with LVN 2. LVN 2 verified Resident 11's HOB was flat while Resident 11 was receiving the enteral feeding. LVN 2 stated Resident 11's HOB should be elevated when she received the enteral feeding. On 4/29/26 at 1538 hours, an interview was conducted with RN 1. RN 1 stated when the residents were receiving enteral feedings, the HOB should be elevated at least 30 degrees to prevent aspiration. 3. On 4/28/26 at 0531 hours, during the medication administration observation with LVN 3, LVN 3 was observed connecting the enteral syringe to Resident 1's GT. LVN 3 was observed checking Resident (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1's gastric residuals by pulling back on the enteral syringe. LVN 3 then administered 30 ml of water to Resident 1's GT, followed by the simethicone medication and an additional 30 ml of water. LVN 3 then administered the baclofen medication, followed by 30 ml of water. LVN 3 was not observed injecting 20 ml of air into Resident 1's GT prior to the medication administration. On 4/28/26 at 0630 hours, an interview was conducted with LVN 3. LVN 3 stated he did not check Resident 1's GT placement because the licensed staff members checked the tube every shift, and he had completed this at the beginning of his shift. Medical record review for Resident 1 was initiated on 4/27/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's Care Plan Report showed a plan of care revised 8/3/23, addressing Resident 1's risk for malnutrition, dehydration, weight loss, and altered fluid balance related to NPO status with enteral feeding dependency. The interventions included checking the GT placement and gastric contents/residual volume per facility protocol, and holding the enteral feeding if residuals were greater than 75 ml. 4. On 4/28/26 at 0544 hours, during the medication administration observation for Resident 17 with LVN 3, Resident 17 was observed in bed receiving enteral feeding via the enteral pump. LVN 3 stopped the pump, connected the enteral syringe, and administered 10 ml of water to Resident 17's GT. LVN 3 then administered the simethicone medication and an additional 5 ml of water. LVN 3 then restarted the feeding pump. LVN 3 was not observed aspirating gastric contents or injecting 20 ml of air to Resident 17's GT prior to medication administration. Medical record review for Resident 17 was initiated on 4/27/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/26/25, showed Resident 17 had a GT. Review of Resident 17's Care Plan Report showed a plan of care revised 10/23/25, addressing Resident 17's GT use related to his swallowing problem. The interventions included checking the GT placement and gastric contents/residual volume per facility protocol. On 4/28/26 at 0630 hours, an interview was conducted with LVN 3. LVN 3 stated he did not check Residents 17 and 22's residuals or GT placement because the licensed staff members checked the tube every shift, and he had completed this at the beginning of his shift. On 4/28/26 at 0854 hours, an interview was conducted with LVN 2. LVN 2 stated the tube placement should be checked every time medications were administered through the enteral tube to ensure the tube was functioning properly. On 4/30/26 at 0954 hours, an interview was conducted with the IP. The IP stated prior to medication administration via GT, the licensed nurse should verify placement and patency of the GT by checking the resident's gastric residuals and by auscultating with a stethoscope while injecting air through the GT to ensure the medications were administered to the correct location. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 4/28/26 at 0634 hours, a medication administration observation for Resident 6 and concurrent interview was conducted with RN 3. RN 3 was observed preparing and administering 4 ml of sucralfate suspension medication via GT without verifying the GT placement. When RN 3 was asked how to check for GT placement, RN 3 stated GT placement was checked using a stethoscope and injecting air. RN 3 acknowledged she did not check GT placement using a stethoscope prior to medication administration. Medical record review for Resident 6 was initiated on 4/27/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 3/17/26, showed Resident 6 was GT dependent. Review of Resident 6's care plan showed a plan of care dated 8/6/23, addressing Resident 6's feeding tube use related to her swallowing problem. The interventions included checking the GT placement and gastric contents/residual volume per facility protocol. On 4/29/26 at 1607 hours, an interview was conducted with RN 5. RN 5 was informed of the above findings and stated GT placement should have been checked prior to medication administration to ensure GT was not dislodged. Cross Reference to F726, example #4. 6. On 4/28/26 at 0536 hours a medication administration observation for Resident 10 and concurrent interview was conducted with LVN 4. LVN 4 was observed preparing and administering the following medications without verifying the GT placement: - erythromycin (antibiotic) 500 mg oral solution 1.13 ml; - sodium chloride 23.4% oral solution 3.75 ml; and - tizanidine (muscle relaxer) 2 mg tablet half tablet (1 mg). When LVN 4 was asked about the facility's GT medication administration protocol, LVN 4 stated she would have to check the facility's protocol but acknowledged she did not check GT placement using a stethoscope prior to medication administration. Medical record review for Resident 10 was initiated on 4/28/26. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. On 4/28/26 at 0555 hours, an interview was conducted with RN 4. RN 4 was informed of the above findings and stated GT placement should have been checked prior to medication administration to ensure GT patency. On 4/30/26 at 1416 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings for Residents 6 and 10. Cross Reference to F726, example #5

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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, medical record review, facility document review, and facility P&P review, the facility failed to ensure three of four licensed nurses observed for medication administration demonstrated competency verifying GT placement prior to administering medications (LVNs 3 and 4 and RN 3). * LVN 3 failed to verify the GT placement prior to administering the medications for Residents 1, 17, and 22. * RN 3 failed to verify the GT placement prior to administering the medications for Resident 6. * LVN 4 failed to verify the GT placement prior to administering the medications for Resident 10. These failures had the potential to place the residents at risk for unsafe and improper care, including aspiration and complications related to incorrect tube placement. Findings: Review of the facility's P&P titled Medication Administration; oral; IM; SQ; ID; Metered Dose; NGT; GT; JT; Vaginal, Urethral; Suppository; Eye & Ear Drops revised 4/2022 showed the procedure for administering medications via NGT and GT included to elevate the head of the bed, confirm placement of the tube by aspiration contents and/or injecting 20 ml of air; aspiration would result if tube was not in the stomach. Review of the facility's document titled Medication Administration dated 2/28/25, showed a lesson plan that contained instructions for the use of NGT/GT. The instructions included checking the placement of the tube and checking the gastric residuals immediately before administering medications. 1. Medical record review for Resident 22 was initiated on 4/27/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's MDS assessment dated [DATE], showed Resident 22 used a feeding tube. Review of Resident 22's Care Plan Report showed a care plan problem revised 8/18/23, addressing Resident 22's alteration in gastrointestinal status related to her NPO status and enteral feeding dependency. The interventions included elevating the head of bed during and thirty minutes after tube feeding and checking for tube placement and gastric contents/residual volume per facility protocol. On 4/28/26 at 0605 hours, a medication administration observation was conducted with LVN 3 for Resident 22. LVN 3 was observed preparing the following medications:- one tablet of baclofen (muscle relaxant) 20 mg,- one bottle of dextran ophthalmic solution (eye lubricant),- one bottle of artificial saliva moisturizing gel (oral moisturizer),- four ml of glycopyrrolate liquid solution (used to reduce chronic severe drooling), and- one bottle of nighttime relief lubricant eye ointment. On 4/28/26 at 0612 hours, during the medication administration observation with LVN 3, LVN 3 was observed connecting the enteral syringe to Resident 22's GT. LVN 3 was observed administering multiple medications and water through the resident's GT but did not verify the GT placement by aspirating gastric contents or injecting 20 ml of air prior to administering the medications and water. Cross Reference to F693, example #1. 2. Medical record review for Resident 1 was initiated on 4/27/26. Resident 1 was admitted to the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a feeding tube. Review of Resident 1's Care Plan Report showed a plan of care revised 8/3/23, addressing Resident 1's risk for malnutrition, dehydration, weight loss, and altered fluid balance related to NPO status with enteral feeding dependency. The interventions included checking the GT placement and gastric contents/residual volume per facility protocol, and holding the enteral feeding if residuals were greater than 75 ml. On 4/28/26 at 0523 hours, a medication administration observation was conducted with LVN 3 for Resident 1. LVN 3 was observed preparing the following medications:- three tablets of baclofen 10 mg,- one chewable tablet of simethicone (medication to relieve excess gas and bloating) 80 mg, and- one tube of Aquaphor (protects and soothes dry skin) ointment. On 4/28/26 at 0531 hours, during the medication administration observation with LVN 3, LVN 3 was observed connecting the enteral syringe to Resident 1's GT. LVN 3 was observed checking Resident 1's gastric residuals by pulling back on the enteral syringe. LVN 3 then administered 30 ml of water to Resident 1's GT, followed by the simethicone medication and an additional 30 ml of water. LVN 3 then administered the baclofen medication, followed by 30 ml of water. LVN 3 was not observed injecting 20 ml of air into Resident 1's GT prior to the medication administration. Cross Reference to F693, example #3. 3. Medical record review for Resident 17 was initiated on 4/27/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/26/25, showed Resident 17 had a GT. Review of Resident 17's Care Plan Report showed a plan of care revised 10/23/25, addressing Resident 17's GT use related to his swallowing problem. The interventions included checking the GT placement and gastric contents/residual volume per facility protocol. On 4/28/26 at 0543 hours, a medication administration observation was conducted with LVN 3 for Resident 17. LVN 3 was observed preparing 0.3 ml of simethicone medication. On 4/28/26 at 0544 hours, during the medication administration observation for Resident 17 with LVN 3, Resident 17 was observed in bed receiving enteral feeding via the enteral pump. LVN 3 stopped the pump, connected the enteral syringe, and administered 10 ml of water to Resident 17's GT. LVN 3 then administered the simethicone medication and an additional 5 ml of water. LVN 3 then restarted the feeding pump. LVN 3 was not observed aspirating gastric contents or injecting 20 ml of air to Resident 17's GT prior to medication administration. On 4/28/26 at 0630 hours, an interview was conducted with LVN 3. LVN 3 stated he did not check Residents 17 and 22's residuals or GT placement because the licensed staff members checked the tube every shift, and he had completed this at the beginning of his shift. On 4/28/26 at 0854 hours, an interview was conducted with LVN 2. LVN 2 stated the tube placement should be checked every time medications were administered through the enteral tube to ensure the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tube was functioning properly. On 4/30/26 at 0954 hours, an interview was conducted with the IP. The IP stated prior to medication administration via GT, the licensed nurse should verify placement and patency of the GT by checking the resident's gastric residuals and by auscultating with a stethoscope while injecting air through the GT to ensure the medications were administered to the correct location. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings. Cross Reference to F693, example #4. 4. On 4/28/26 at 0634 hours, a medication administration observation for Resident 6 and concurrent interview was conducted with RN 3. RN 3 was observed preparing and administering 4 ml of sucralfate suspension medication via GT without verifying the GT placement. When RN 3 was asked how to check for GT placement, RN 3 stated GT placement was checked using a stethoscope and injecting air. RN 3 acknowledged she did not check GT placement using a stethoscope prior to medication administration. Medical record review for Resident 6 was initiated on 4/27/26. Resident 6 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 6's H&P examination dated 3/17/26, showed Resident 6 was GT dependent. Review of Resident 6's care plan showed a plan of care dated 8/6/23, addressing Resident 6's feeding tube use related to her swallowing problem. The interventions included checking the GT placement and gastric contents/residual volume per facility protocol. On 4/29/26 at 1607 hours, an interview was conducted with RN 5. RN 5 was informed of the above findings and stated GT placement should have been checked prior to medication administration to ensure GT was not dislodged. Cross Reference to F693, example #5. 5. On 4/28/26 at 0536 hours a medication administration observation for Resident 10 and concurrent interview was conducted with LVN 4. LVN 4 was observed preparing and administering the following medications without verifying the GT placement: - erythromycin (antibiotic) 500 mg oral solution 1.13 ml; - sodium chloride 23.4% oral solution 3.75 ml; and - tizanidine (muscle relaxer) 2 mg tablet half tablet (1 mg). When LVN 4 was asked about the facility's GT medication administration protocol, LVN 4 stated she would have to check the facility's protocol but acknowledged she did not check GT placement using a stethoscope prior to medication administration. Medical record review for Resident 10 was initiated on 4/28/26. Resident 10 was admitted to the (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE] and readmitted on [DATE]. On 4/28/26 at 0555 hours, an interview was conducted with RN 4. RN 4 was informed of the above findings and stated GT placement should have been checked prior to medication administration to ensure GT patency. On 4/30/26 at 1416 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings for Residents 6 and 10. Cross Reference to F693, example #6.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the sanitary conditions were maintained in the kitchen. * The facility failed to ensure the hood over the stove was maintained in a sanitary condition. * The facility failed to ensure the kitchen utensils had a smooth cleanable surface and were kept in good repair. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were maintained in a sanitary condition and had smooth, cleanable surfaces. These failures had the potential for cross contamination and foodborne illnesses to the two residents consuming the food prepared in the facility's kitchen.Findings: Review of the facility's Diet Type Report dated 4/28/26, showed two of 21 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Kitchen Ansul Hood Fire Suppression System date revised 3/2022 showed the kitchen's Ansul hood system must remain in safe working condition, be regularly inspected, and be free of grease accumulation. Dietary staff must ensure hood, filters, and surrounding surfaces are free of visible grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 4/27/26 at 0842 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the CDM. The kitchen hood over the stove had yellowish, greasy residue. The CDM acknowledged the observation and stated the dietary staff cleaned the hood once a week and the hood was also serviced by an outside company. The sticker on the hood showed it was last serviced on 2/11/26. 2. Review of the facility's P&P titled Cleaning and Sanitizing Utensils and Cutting boards date revised 4/2025 showed to ensure all utensils, cutting boards, and food contact surfaces are properly cleaned and sanitized to prevent foodborne illness and maintain compliance with California health regulations and infection control standards. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 4/27/26 at 0842 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the CDM. The following was observed and verified by the CDM: - One red peeler with black handle, discolored and worn out.- One light blue rubber basting brush was discolored with yellowish stains at the base.- One stainless steel can opener with orange discoloration, consistent with rust.- Three white rubber spatulas with red handles, partially melted; one had peeling rubber edges and discoloration. 3. Review of the facility's P&P titled Cleaning and Sanitizing Utensils and Cutting boards date revised 4/2025 showed to ensure all utensils, cutting boards, and food contact surfaces are properly cleaned and sanitized to prevent foodborne illness and maintain compliance with California health regulations and infection control standards. All utensils and cutting boards must be cleaned and sanitized after each use and between preparation of different food types to prevent cross-contamination, in accordance with the California Retail Food Code (CalCode) and applicable public health standards. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 4/27/26 at 0842 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the CDM. The following was observed and verified by the CDM: - One stainless steel slotted scoop with green handle had fuzzy film and watermarks.- One stainless steel scoop with gray handle, dirty, with fuzzy film and watermarks.- One stainless steel scoop with black handle had fuzzy film and watermarks. - Two stainless steel scoops with green handles had fuzzy film and watermarks. - One stainless steel scoop with blue handle with watermarks and dry crusted residue. - One stainless steel spatula with wooden handle, dirty with orange residue, fuzzy film and watermarks. - One stainless steel scissor with black handle, dirty with dry crusted residue. 4. Review of the facility's P&P titled Cleaning and Sanitizing Utensils and Cutting boards date revised 4/2025 showed to use color-coded cutting boards to prevent cross-contamination. Clean and sanitize cutting boards after each use and between different food types. Inspect cutting boards regularly. Discard or resurface if deeply scratched, cracked, or worn. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 4/27/26 at 0842 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the CDM. The green, red and yellow cutting boards were observed fuzzy, heavily marred and had deep groves. The CDM verified the findings and stated the thin cutting boards were replaced every six months. On 4/29/26 at 1505 hours, a follow-up interview was conducted with the CDM. The CDM acknowledged all the above findings and stated the following: - The hood over the stove should not have any grease residue due to fire hazard and infection control purposes. - All dirty and worn-out utensils and kitchenware should have been washed, discarded and replaced for infection control purposes.- The cutting boards should have been replaced because the deep grooves could not be cleaned thoroughly. On 4/30/26 at 1416 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in three of three garbage dumpsters. * The facility failed to ensure the two garbage dumpster lids had fully closed lids and one dumpster had a lid in place. This failure had the potential to attract pest/rodents that carried diseases.Findings: Review of the facility's P&P titled Non-Medical Waste Management revised date 1/2026 showed non-biomedical waste (general trash) must be disposed of in the designated hospital dumpsters. Staff must ensure that trash bags are securely tied before disposal and dumpster lids remain closed to prevent pests and odors. According to the 2022 FDA (Food and Drug Administration) Food Code, the outside garbage receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. On 4/27/26 at 0929 hours, an observation with the CDM was conducted of the facility's three outside garbage dumpsters. Two of the garbage dumpsters had lids partially propped open due to garbage bags and cardboard boxes, preventing full closure. The third dumpster was observed without a lid and was fully open with garbage bags exposed. On 4/27/26 at 0938 hours, an interview was conducted with the Maintenance Director/Plant Operations Director. The Maintenance Director/Plant Operations Director was shown a photograph taken on 4/27/26 at 0929 hours, showing the above observations for the three dumpsters. The Maintenance Director/Plant Operations Director verified the above findings and stated the dumpster lids should be fully closed to prevent trash from coming out of the containers. On 4/29/26 at 1505 hours, a follow-up interview was conducted with the CDM. The CDM verified the above findings and stated the garbage dumpsters should have lids and the lids should be closed to prevent items from entering or exiting of the trash containers and to maintain infection control. On 4/30/26 at 1416 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide a safe and sanitary environment for four of nine residents (Residents 1, 17, 18, and 22) observed during medication administration observation. * During the medication administration observation for Resident 1, LVN 3 failed to don PPE gown for EBP precautions. In addition, LVN 3 failed to perform hand hygiene in between the glove changes. * During the medication administration observation for Residents 17 and 22, LVN 3 failed to don PPE gown for EBP precautions. * The facility failed to ensure RN 6 donned PPE, including gloves, prior to taking Resident 18's vital signs in an EBP room. These failures posed the risk for transmission of infection to residents, staff, and visitors.Findings: Review of the facility's P&P titled Hand Hygiene revised 2/2023 showed hand hygiene was the single most effective measure to reduce the spread of infection and all staff should comply with the hand hygiene policy. In addition, hands should always be decontaminated before donning and after removing gloves. Review of the facility's P&P titled Enhanced Barrier Precautions revised 8/2024 showed enhanced barrier precautions (EBP) was implemented to reduce the risk of transmission of Multidrug-Resistant Organisms (MDRO) within the facility. Enhanced barrier precautions utilized the use of gowns and gloves for when high-contact patient care activities were indicated; examples of high-contact patient activities included device care (central line, urinary catheter, feeding tube, and tracheostomy/ventilator). 1. Medical record review for Resident 1 was initiated on 4/27/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 had a feeding tube. Review of Resident 1's Order Summary Report showed a physician's orders dated 6/20/23, to provide enhanced standard precautions every shift for infection prevention. On 4/28/26 at 0523 hours, a medication administration observation was conducted with LVN 3 for Resident 1. LVN 3 was observed preparing the following medications:- three tablets of baclofen (muscle relaxant) 10 mg,- one chewable tablet of simethicone (medication to relieve excess gas and bloating) 80 mg, and- one tube of Aquaphor (protects and soothes dry skin) ointment. On 4/28/26 at 0531 hours, an enhanced barrier sign was posted outside of Resident 1's room. The sign indicated providers and staff must wear gloves and gown for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, assisting with toileting, device care or use for central lines, urinary catheter, feeding tube, and tracheostomy, and wound care. LVN 3 was observed performing hand hygiene and donning gloves when he entered Resident 1's room to administer the medications. However, LVN 3 was not observed wearing a gown. After administering Resident 1's medications via GT, LVN 3 was observed removing his gloves and donning a new pair of gloves without performing hand hygiene. LVN 3 then administered Resident 1's topical medication. 2. Medical record review for Resident 17 was initiated on 4/27/26. Resident 17 was admitted to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Review of Resident 17's H&P examination dated 9/26/25, showed Resident 17 had a GT. Review of Resident 17's Order Summary Report showed a physician's orders dated 1/13/26, to provide enhanced barrier precautions every shift for infection prevention. On 4/28/26 at 0543 hours, a medication administration observation was conducted with LVN 3 for Resident 17. LVN 3 was observed preparing 0.3 ml of simethicone medication. On 4/28/26 at 0544 hours, an enhanced barrier sign was posted outside of Resident 17's room. LVN 3 was observed performing hand hygiene and donning gloves when he entered Resident 17's room to administer the resident's medication via GT. However, LVN 3 was not observed wearing a gown. 3. Medical record review for Resident 22 was initiated on 4/27/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's MDS assessment dated [DATE], showed Resident 22 used a feeding tube. Review of Resident 22's Order Summary Report showed a physician's orders dated 1/13/26, to provide enhanced barrier precautions every shift for infection prevention. On 4/28/26 at 0605 hours, a medication administration observation was conducted with LVN 3 for Resident 22. LVN 3 was observed preparing the following medications:- one tablet of baclofen 20 mg,- one bottle of dextran ophthalmic solution (a medication to relieve dry eyes),- one bottle of artificial saliva moisturizing gel (a medication to relieve dry mouth symptoms),- four ml of glycopyrrolate (a medication to reduce severe drooling) liquid solution, and- one bottle of nighttime relief lubricant eye ointment. On 4/28/26 at 0612 hours, an enhanced barrier sign was posted outside of Resident 22's room. LVN 3 was observed performing hand hygiene and donning gloves when he entered Resident 22's room to administer the medications. However, LVN 3 was not observed wearing a gown. On 4/28/26 at 0630 hours, an interview was conducted with LVN 3. LVN 3 stated when providing care for the residents with EBP, the staff members should wear a mask, gown, and gloves. LVN 3 verified he did not wear a gown when he administered Resident 1,17, and 22's GT medication and he did not perform hand hygiene between the glove use during the medication administration observation for Resident 1. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings. 4. On 4/28/26 at 0838 hours, during the medication administration observation with RN 6 for Resident 18. RN 6 was observed taking Resident 18's vital signs inside the room (with EBP precautions) prior to medication administration, however, RN 6 was not wearing PPE, such as gloves. Review of Resident 18's medical record was initiated on 4/28/26. Resident 18 was admitted to the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility on [DATE]. Review of the Physician H&P examination dated 9/6/25, showed Resident 18 had global developmental delay and GT dependent. Review of Resident 18's Order Summary Report for 4/2026 showed a physician's order dated 1/13/26, for enhanced barrier precautions during high contact care for infection prevention protocol. On 4/28/26 at 0916 hours, an interview was conducted with RN 6. RN 6 acknowledged the above findings and stated there was no need to wear the gloves when taking vital signs or turning off feeding pumps, since she was not actually rendering care or touching any other lines. On 4/29/26 at 1557 hours, an interview was conducted with RN 5. RN 5 was informed of the above findings and stated the PPE required for EBP included gown, gloves, and mask for high contact care, however, gloves should be worn when touching the resident. On 4/30/26 at 0951 hours, an interview was conducted with the IP. The IP was informed of the above findings and stated the PPE required for EBP included gloves and gown for high contact care such as dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, device care and wound care. When asked if the vital signs check was considered contact care, the IP stated, RN 6 should have at least worn gloves when touching the resident. On 4/30/26 at 1416 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the antibiotic stewardship program was monitored, and addressed the use of the antibiotics for two of 12 final sampled residents (Residents 3 and 19) and one nonsampled resident (Resident 9). * The facility failed to monitor and address the use of antibiotics when the resident's condition did not meet McGeer's criteria. This failure had the potential for antibiotics to be used when it was not indicated and the development of antibiotic-resistant bacteria.Findings: Review of the facility's P&P titled 2026 Infection Prevention Program Plan and Policy dated 1/2026 showed the infection surveillance will follow the standardized McGeers's Criteria in the subacute unit. The Infection Prevention Program will assure appropriate use of antibiotics through active participation in the antibiotic stewardship committee. Review of the facility's P&P titled Antibiotic Stewardship Program revised 1/2022 showed the facility will established an antibiotic stewardship program team accountable for stewardship activities. The Infection Preventionist will review infections and monitor antibiotic usage patterns on a regular basis. The IP will include a separate report on the number of residents on antibiotics that did not meet the criteria for active infection. An antibiotic review process, also known as antibiotic time-out (ATO) for all antibiotics prescribed in the facility. ATO's prompt clinicians to reassess the ongoing need for a choice of antibiotic when the clinical picture is clearer and more information available. The ATO can be considered a stop order of an antibiotic when diagnostic test results or symptoms of the resident do not support the diagnosis of infection. Review of the facility's Subacute Surveillance Line Listing for March 2026 showed the following:- Resident 3 was prescribed levofloxacin (antibiotic medication) 250 mg. However, the McGeer's Criteria for true infection was not met;- Resident 19 was prescribed Augmentin (antibiotic medication) 500 mg. However, McGeer's Criteria for true infection was not met; and - Resident 9 was prescribed ciprofloxacin (antibiotic medication) 500 mg. However, the McGeer's Criteria for true infection was not met. Review of the Revised McGeer Criteria for Surveillance Checklist for Residents 3, 9, and 19 (undated) showed each resident exhibited signs and symptoms of infection; however, the residents did not meet the criteria for true infection based on the checklist. On 4/30/26 at 1107 hours, an interview, facility document review and concurrent facility P&P review was conducted with the IP. The IP stated the facility used McGeer's Criteria as part of its antibiotic stewardship program. The IP stated for the residents who DNMC and were prescribed antibiotic medications, the facility completed the ATO, which was documented in the resident's medical record. The IP stated the physician reviewed the resident's signs and symptoms with the RN supervisor to determine if continuation of antibiotic therapy was appropriate. The IP was able to show the documentation of the ATO for Residents 3, 9, and 19, showing the physician was made aware of the residents' signs and symptoms and opted to continue the course of the antibiotic therapy. However, the IP was asked if the prescribing physician documented the clinical rationale for continuing the antibiotic medication despite not meeting the criteria, the IP verified there was no physician's progress note documented to show the rational for the continuation use of the antibiotic medication for the residents. On 4/30/26 at 1416 hours, an interview and concurrent medical record review was conducted with the ADON. The ADON 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 resident's dignity was maintained for two of 12 final sampled residents (Residents 3 and 23). * The facility failed to ensure Resident 3 and 23's indwelling urinary catheter drainage bag were covered. These failures had the potential to negatively affect the residents' sense of dignity and well-being. Findings: Review of the facility's P&P titled Management of Urinary Catheter Drainage Bags date revised 4/2022 showed all the urinary catheter drainage systems shall be maintained as a closed system and handled using aseptic technique to reduce the risk of catheter-associated urinary tract infections (CAUTIs). Staff will follow evidence-based practices for drainage bag positioning, emptying, and replacement. 1. On 4/27/26 at 0825 hours and 4/28/26 at 0838 hours, Resident 23 was observed in bed with the indwelling urinary catheter drainage bag placed at the side of the bed and uncovered. Medical record review for Resident 23 was initiated on 4/27/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's MDS assessment dated [DATE], showed Resident 23 had an indwelling urinary catheter and required total assistance from the staff for all the ADL care. On 4/28/26 at 0838 hours, an observation and concurrent interview for Resident 23 was conducted with RN 2. RN 2 verified the resident had a suprapubic urinary catheter with a drainage bag. When asked about the drainage bag being placed at the side of the bed, RN 2 stated it must be kept below the level of the bladder to ensure proper drainage. RN 2 was asked about the facility's process for ensuring privacy for the urinary catheter drainage bags, RN 2 stated the facility staff would place the drainage bag at the side of the bed without any covering. RN 2 denied the facility practice of using a privacy or dignity covers for the urinary catheter drainage bags. On 4/29/26 at 1204 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. When asked about the facility's expectations for the indwelling urianry catheter drainage bags, RN 1 stated the drainage bag should be placed in a dignity cover or privacy bag to protect the resident's privacy. RN 1 was informed of the observations and verified the findings. On 4/30/26 at 1416 hour, an interview and concurrent medical record review for Resident 23 was conducted with the ADON. The ADON was informed and verified the above findings. 2. On 4/28/26 at 0800 and 0829 hours, Resident 3 was observed in bed with the indwelling urinary catheter drainage bag placed at the side of the bed by near the room entrance and uncovered. Medical record review for Resident 3 was initiated on 4/27/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's Quarterly MDS assessment dated [DATE], showed Resident 3 had an indwelling urinary catheter with intermittent catheterization and was dependent on staff for her activities of daily living. (continued on next page)

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 3's care plan addressing the resident's intermittent catheterization dated 1/21/26, showed an intervention dated 1/30/26, to position the catheter bag and tubing below the level of the bladder and away from the room entrance door. On 4/30/26 at 1222 hours, an interview and concurrent medical record review for Resident 3 was conducted with the ADON. The ADON was shown a photograph taken on 4/28/26 at 0836 hours, showing the uncovered urinary catheter drainage bag. The ADON verified the observation and stated the urinary catheter drainage bag should have been placed inside a dignity bag to protect the resident's dignity. On 4/30/26 at 1416 hours, an interview was conducted with the DON. 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
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to implement their abuse P&P for one of 12 final sampled residents (Resident 19). * The facility failed to assess Resident 19 when the resident reported an allegation of abuse against a staff member. In addition, the facility failed to monitor Resident 19 after Resident 19 reported an allegation of abuse. These failures posed the risk for the delay of identifying the negative outcomes to the resident and implementation of the necessary interventions after a report of an allegation of abuse. Findings: Review of the facility's P&P titled Abuse revised date 1/2026 showed the following: - It is the policy of this facility to establish an environment for all residents that is free from abuse, neglect, misappropriation of personal property, corporal punishment and involuntary seclusion. The facility will follow a seven step process to prevent, detect and report any mistreatment, neglect, or abuse of the resident; - Under Reporting/Response showed, the staff will monitor residents who have been abused and document findings at least once per shift for a minimum of 72 hours or until their medical condition, mood and function have stabilized (whichever is greater), and periodically thereafter. Staff will ensure that basic, medical, functional and psychosocial needs are being met and that potentially preventable or treatable conditions affecting function and quality of life are addressed appropriately; and - Under Investigation showed, the licensed nurse will assess the individual and document related findings. Assessment date will include: injury assessment (bleeding, bruising, deformity, swelling, etc). Documentation in the medical record will include objective data and a care plan is initiated to reflect the resident's condition and measures to be taken to prevent recurrence. Review of the facility's SOC-341 dated 4/21/26, showed Resident 19 verbalized to the facility staff a CNA touched his private parts while in the shower on an unknown date. Medical record review for Resident 19 was initiated on 4/27/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 12/16/25, showed Resident 19 had a diagnosis of anoxic brain injury and had no decision-making capacity. Review of Resident 19's Quarterly MDS assessment dated [DATE], showed Resident 19 required total assistance from staff for all ADL care. Review of Resident 19's medical records failed to show any documentation if Resident 19 was assessed after an allegation of abuse was reported. In addition, review of Resident 19's medical records failed to show documentation if Resident 19 was monitored after the abuse allegation was reported. On 4/29/26 at 1613 hours, an interview and concurrent medical record review for Resident 19 was conducted with RN 5. RN 5 stated an allegation of abuse was considered a change of condition. However, RN 5 verified there were no change of condition assessment documentation initiated and no skin assessment was documented after Resident 19 reported an allegation of abuse. RN 5 stated it should have been done. On 4/30/26 at 1222 hours, an interview and concurrent record review for Resident 19 was conducted with the ADON. The ADON verified the change of condition assessment, skin assessment and resident monitoring were not completed for Resident 19 when the abuse allegation was reported. On 4/30/26 at 1409 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to develop a care plan for two of 12 final sampled residents (Residents 5 and 19). * The facility failed to develop a care plan to address Resident 5's use of anticoagulant medication. * The facility failed to develop a care plan to address Resident 19's use of bilateral side rails. These failures had the potential for the resident needs not being communicated to the IDT, placing the residents at risk of not being provided with appropriate, consistent, and individualized care.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 5/2024 showed the interdisciplinary team, in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The comprehensive, person-centered care plan includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 1. Medical record review for Resident 5 was initiated on 4/27/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 11/22/25, showed Resident 5 had no decision-making capacity. Review of Resident 5's MDS assessment dated [DATE], showed Resident was receiving anticoagulant medication. Review of Resident 5's Order Summary Report dated 4/28/26, showed a physician's order dated 2/9/26, to administer enoxaparin sodium injection (anticoagulant medication) 30 mg/0.3 ml subcutaneously in the evening for DVT prophylaxis. Further review of the Order Summary Report failed to show a physician's order for monitoring for side effects or adverse reactions related to anticoagulant therapy. Review of Resident 5's plan of care failed to show a care plan problem was developed to address the resident's use of an anticoagulant medication. Additionally, there was no care plan problem or intervention indicating the need to monitor for signs and symptoms of bleeding or other complications associated with anticoagulant therapy. On 4/29/26 at 1136 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 verified Resident 5's use of anticoagulant medication for DVT prophylaxis. When asked to provide the care plan addressing the resident's anticoagulant use, RN 1 was unable to show any care plan problem or interventions related to anticoagulant therapy. RN 1 verified and acknowledged a care plan should have been developed for the resident's anticoagulant use. On 4/30/26 at 1416 hours, an interview and concurrent medical record review for Resident 5 was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with the ADON. The ADON was informed and verified the above findings. 2. Medical record review for Resident 19 was initiated on 4/27/26. Resident 19 was admitted to the facility on [DATE]. Review of Resident 19's H&P examination dated 12/16/25, showed Resident 19 had a diagnosis of anoxic brain injury and had no decision-making capacity. Review of Resident 19's Quarterly MDS assessment dated [DATE], showed Resident 19 required total assistance from staff for all ADL care. Review of Resident 19's Order Summary Report for 4/2026 showed a physician's order dated 1/28/26, for bilateral side rails up for safety. Review of Resident 19's plan of care failed to show a care plan problem was developed to address the resident's use of bilateral side rails. On 4/29/26 at 1613 hours, an interview and concurrent medical record review was conducted with RN 5. RN 5 verified Resident 19's use of bilateral side rails and acknowledged a care plan should have been developed for the resident's use of bilateral side rails to ensure the staff were on the same page regarding resident's care. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were 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, and facility P&P review, the facility failed to provide the necessary care and services to ensure one nonsampled resident (Resident 17) was free from accident hazards. * The facility failed to provide padded side rails for seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) precautions per the physician's order for Resident 17. This failure placed Resident 17 at risk for serious injury.Findings: Review of the facility's P&P titled Bed Safety and Bed Rails revised 6/2022 showed that consideration was given to the resident's safety, medical condition, comfort, and freedom of movement, as well as input from the resident and family. On 4/27/26 at 0938 and 1535 hours, 4/28/26 at 1015 hours, and at 4/29/26 at 0914 hours, Resident 17 was observed in bed with side rails in use. The side rails were not padded. Medical record review for Resident 17 was initiated on 4/27/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/26/25, showed Resident 17 had a diagnosis of seizure. Review of Resident 17's Side Rail Assessment Form dated 9/26/25, showed Resident 17's family member had requested the use of the side rails while the resident was in bed for safety and/or comfort, and noted seizure precautions as the reason for the use. Review of Resident 17's Order Summary Report showed a physician's order dated 4/24/26, to provide a padded side rails for seizure precautions. On 4/29/26 at 0929 hours, an interview and concurrent observation of Resident 17 was conducted with LVN 2. LVN 2 verified Resident 17's side rails were not padded. LVN 2 stated Resident 17's family had declined the use of the padded side rails for Resident 17's seizure precautions. LVN 2 also stated the refusal of the physician's order for the padded side rails should be documented in Resident 17's medical record. On 4/29/26 at 1046 hours, a follow-up interview and concurrent observation of Resident 17 was conducted with LVN 2. Resident 17 was observed in bed with padded siderails in place. LVN 2 stated she was unable to locate documentation in the resident's medical record to show the family had declined the use of the padded side rails. LVN 2 also stated she did not see an order for the padded side rails on Resident 17's MAR and acknowledged the physician's order had been missed. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care services for two of 12 final sampled residents (Residents 4 and 10) reviewed for respiratory care. * The facility failed to ensure Resident 4 and 10's oxygen tubing were stored in a sanitary condition when not in use. These failures had the potential to negatively affect the respiratory health and well-being of the residents in the facility.Findings: Review of the facility's P&P titled Changing Respiratory Equipment revised 1/2025 showed the oxygen masks and cannulas will be changed weekly and as needed. All respiratory disposable treatment equipment will be dated when changed weekly. 1. On 4/27/26 at 0918 hours and 4/28/26 at 0852 hours, Resident 4 was observed in bed. Resident 4's oxygen tubing was observed hanging on the wall hook. The tubing was unlabeled, undated, and not stored inside the clear plastic bag setup bag. Medical record review for Resident 4 was initiated on 4/27/26. Resident 4 was admitted to the facility on [DATE], with a diagnosis of chronic respiratory failure. Review of Resident 4's Order Summary Report dated 4/28/26, showed a physician's order dated 3/20/24, to provide cool aerosol during nights with FLO2 to keep oxygen saturation above 92%. 2. On 4/27/26 at 0955 hours and 4/28/25 at 0852 hours, Resident 10 was observed in bed. Resident 10's oxygen tubing was observed coiled around the oxygen regulator at the wall. The tubing was unlabeled, undated, and not stored inside the clear plastic setup bag. Medical record review for Resident 10 was initiated om 4/27/26. Resident 10 was admitted to the facility on [DATE], with a diagnosis of chronic respiratory failure. Review of Resident 10's Order Summary Report dated 4/28/26, showed a physician's order dated 11/17/24, to titrate FLO2 to keep oxygen saturation above 92%. On 4/28/26 at 0852 hours, an observation and concurrent interview for Residents 4 and 10 was conducted at bedside with RT 1. RT 1 stated the respiratory staff changed the setup bag weekly the oxygen administrator supplies, nebulizer supplies and ventilator tubing. RT 1 stated the setup bags should be labeled with the resident's name and date. When asked where the oxygen tubing should be stored when not in use, RT 1 stated it should be placed inside the labeled setup bag. When asked about the oxygen tubing observed hanging on the wall hook for Resident 4 and coiled on the oxygen regulator for Resident 10, RT 1 verified the tubing should have been labeled and stored inside the setup bag. On 4/29/26 at 1136 hours, an interview and concurrent medical record review for Residents 4 and 10 was conducted with RN 1. RN 1 stated the respiratory therapists were responsible for the respiratory care and the supplies used for oxygen administration. RN 1 stated the respiratory supplies were changed weekly and labeled with the resident's name and date. RN 1 was informed of the observations regarding unlabeled and undated tubing not stored inside the setup bag. RN 1 verified the findings. On 4/30/26 at 1416, an interview and concurrent medical record review for Residents 4 and 10 was conducted with the ADON. The ADON was informed and verified the above findings.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, medical record review, and facility P&P review, the facility failed to provide pharmaceutical services to meet the resident's need for one of nine residents observed during the medication administration observation. * LVN 3 failed to ensure Resident 22's eye medications were administered per the physician's order. This failure had the potential to negatively affect Resident 22's well-being.Findings: Review of the facility's P&P titled Medication Administration; Oral; IM; SQ; ID; Metered Dose; NGT; GT; JT; Vaginal; Urethral; Suppository; Eye & Ear Drops revised 4/2022 showed the procedure for administering eye drops included to wash hands prior to administration, to place the resident in a comfortable position, to place the medication in the conjunctival sac or if an ointment to place along the inside of the lower lid from the inner to outer canthus, and if the patient was to receive two or more medication, to wait five minutes in between drops. Medical record review for Resident 22 was initiated on 4/27/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Order Summary Report showed the following physician's orders:- dated 11/26/23, to administer dextran 70-hypromellose ophthalmic solution (lubricating eye drop) 0.1-0.3% to bilateral eyes every two hours for dry eyes while awake and to wait five to ten minutes between eye drop medications;- dated 5/1/25, to administer Refresh P.M. (lubricating eye drop) ophthalmic ointment to bilateral eyes every six hours for eye dryness, [NAME] 4/28/26 at 0605 hours, a medication administration observation was conducted with LVN 3 for Resident 22. LVN 3 was observed preparing the following medications:- one tablet of baclofen (muscle relaxant) 20 mg,- one bottle of dextran ophthalmic solution,- one bottle of artificial saliva moisturizing gel,- four ml of glycopyrrolate liquid solution, and- one bottle of nighttime relief lubricant eye ointment. On 4/28/26 at 0620 hours, LVN 3 was observed administering the dextran ophthalmic solution to Resident 22's bilateral eyes. At 0622 hours, LVN 3 was then observed administering the nighttime relief lubricant eye ointment to Resident 22's right eye and at 0624 hours, to the resident's left eye. On 4/28/26 at 0630 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 verified Resident 22's physician's order required waiting five to ten minutes between administering eye drops. LVN 3 verified the above findings. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged 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 interview, medical record review, and facility P&P review, the facility failed to ensure the accuracy of the medical record for one nonsampled resident (Resident 18) was accurate. * Resident 18's medical record contained behavior and side-effect monitoring for the use of the quetiapine (antipsychotic) medication; however, there was no physician's order for the quetiapine medication. This failure had the potential for the resident's care team having inaccurate information.Findings: Review of the facility's P&P titled Charting and Documentation date revised 3/2022 showed all the services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate. Medical record review for Resident 18 was initiated on 4/28/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's Order Summary Report for 4/2026 showed the following physician's orders:- dated 10/5/25, for side-effects monitoring for the quetiapine medication; and- dated 10/14/25, for behavior monitoring for the quetiapine medication.However, the Order Summary Report failed to show a physician's order for the quetiapine medication. Review of Resident 18's eMAR for 4/2026 failed to show a physician's order for the quetiapine medication. On 4/29/26 at 1557 hours, an interview and concurrent medical record review was conducted with RN 5. RN 5 acknowledged the above findings and stated the quetiapine medication order had been discontinued in January 2026, and behavior and side-effect monitoring should have been discontinued as well. On 4/30/26 at 1416 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care was revised to reflect current care needs and interventions for three of 12 final sampled residents (Residents 3, 11, and 23) and one nonsampled resident (Resident 17). * The facility failed to revise Resident 11's care plan to address Resident 11's hospitalization on 3/9/26. * The facility failed to revise Resident 17's care plan for seizure precautions to include padded side rails. * The facility failed to ensure Resident 23's care plan for wound care management was revised to include the use of the low air loss mattress. * The facility failed to ensure Resident 3's care plan for bilateral side rails was revised to remove the intervention of padded side rails. These failures posed the risk of not providing the residents with individualized and person-centered care.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 5/2024 showed a comprehensive, person-centered care plan included measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment, which included the services provided by the facility. In addition, care plans were revised as information about the residents and the residents' condition changes. 1. Medical record review for Resident 11 was initiated on 4/27/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's eINTERACT Transfer Form V6 dated 3/10/26, showed Resident 11 was transferred to an acute care hospital on 3/9/26, due to an uncontrolled nosebleed. Review of Resident 11's Order Summary Report showed the following completed physician's orders:- dated 3/9/26, to transfer Resident 11 to an acute care hospital due to uncontrolled bleeding and a seven-day bed hold.- dated 3/10/26, to not place an NGT to Resident 11's nostril for two weeks due to a deviated septum. However, review of Resident 11's Care Plan Report did not include the resident's hospitalization on 3/9/26. On 4/30/26 at 1040 hours, an interview and concurrent medical record review for Resident 11 was conducted with the ADON. The ADON stated a transfer to an acute care hospital was considered a change in condition to a resident's status and should be reflected in the resident's care plan. The ADON reviewed Resident 11's care plan and verified the resident's care plan did not include the resident's hospitalization on 3/9/26. 2. Medical record review for Resident 17 was initiated on 4/27/26. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/26/25, showed Resident 17 had a diagnosis of seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). (continued on next page)

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F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 17's Care Plan Report showed a care plan problem initiated on 10/23/25, addressing his seizure precautions. The care plan interventions did not include the use of padded side rails. Review of Resident 17's Order Summary Report showed a physician's order dated 4/24/26, to provide padded side rails for seizure precautions. On 4/29/26 at 1046 hours, an observation and concurrent interview was conducted for Resident 17 with LVN 2. Resident 17 was observed in bed with padded side rails. LVN 2 stated Resident 17 should have padded side rails for his seizure precautions. On 4/29/26 at 1558 hours, an interview and concurrent medical record review for Resident 17 was conducted with RN 1. RN 1 stated the purpose of a care plan was to be used as a guide for the resident's care. RN 1 reviewed Resident 17's Care Plan Report and verified Resident 17's use of padded side rails were not included in the resident's care plan. On 4/30/26 at 1409 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above finding for Residents 11 and 17. 3. On 4/27/2026 at 1011 hours, Resident 23 was observed in bed on a low air loss mattress. The low air loss mattress machine pump setting was set at a 400 lbs – firm. Medical record review for Resident 23 was initiated on 4/27/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Order Summary Report dated 4/28/26, showed a physician's order dated 4/20/26, for the resident use of a low air loss mattress every shift for skin breakdown prevention. Review of Resident 23's plan of care showed the care plan problem dated 4/17/26, to address the resident's pressure ulcer. However, the care plan interventions failed to include the use of a low air loss mattress. On 4/29/26 at 1204 hours, an interview and concurrent medical record review for Resident 23 was conducted with RN 1. RN 1 reviewed the resident's care plan and verified the use of the low air loss mattress was not included and should have been added. On 4/30/26 at 1416 hours, an interview and concurrent medical record review for Resident 23 was conducted with the ADON. The ADON was informed and verified the above findings. Cross Reference to F0686, example # 1. 4. On 4/27/26 at 1110 hours, an observation was conducted for Resident 3. Resident 3 was observed lying in bed with bilateral side rails elevated. Medical record review for Resident 3 was initiated on 4/27/26. Resident 3 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 3's H&P examination dated 2/24/22, showed Resident 3's diagnosis included cerebral edema and seizure. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Review of Resident 3's Quarterly MDS assessment dated [DATE], showed Resident 3 was dependent on staff for her ADL care. Review of Resident 3's Order Summary Report for 4/2026 showed a physician's order dated 5/4/23, for bilateral side rails up at all times for safety per the resident's mother's preference. Review of Resident 3's plan of care showed a care plan dated 3/21/23, addressing the resident's high risk for falls. The interventions showed the resident needed a safe environment with padded side rails up per physician's order dated 5/21/24. However, the resident's medical record did not include a physician's order for padded side rails. On 4/30/26 at 1222 hour, an interview and concurrent medical record review for Resident 3 was conducted with the ADON. The ADON was informed and verified the above findings. The ADON stated the care plan should have matched the physician's order because the care plan reflected the care rendered to the resident. On 4/30/26 at 1416 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.