STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555755	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Healthcare Center	8101 E Hill Drive Rosemead, CA 91770

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to obtain a complete informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) prior to administration psychotropic medications (medications that affects mood and behavior) for three of three sampled residents (Residents 10, 72, and 82) and keep the consent in the resident's clinical record by failing to ensure: 1. Resident 10's consent for Divalproex Sodium (medication used to stabilize mood) and Olanzapine (a medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought]) was signed and dated by the physician who obtained the consent. 2a. Resident 72's informed consent for Haloperidol (medication used to treat schizophrenia]) Olanzapine and Quetiapine Fumarate (medication to treat schizophrenia, bipolar disorder (mental health condition that causes a person to experience extreme mood changes) and major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interests]) did not have a physician's signature or date since 2/18/2026. 2b. Resident 72's informed consent obtained by the physician for Quetiapine Fumarate did not indicate the probable side effects were explained to the resident or responsible party. 3.Resident 82's informed consent for Bupropion HCL (medication to treat major depressive disorder), Risperdal (medication to treat schizophrenia and bipolar disorder) and Olanzapine did not have a physician's signature or date since 3/6/2026. This deficient practice had the potential for residents to receive psychotropic medications without proper consent, which could result in unwanted treatment and violation of resident rights. Furthermore, this exposed residents to psychotropic medications without being fully informed of risks, benefits, and side effects, which may increase the likelihood of unrecognized or unmanaged adverse drug reactions. Findings: 1. During a review of Resident 10's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with diagnoses including hypertensive heart disease without heart failure (heart problems caused by long-term high blood pressure) and schizoaffective disorder (a chronic mental illness causing significant changes in thoughts, moods, and behaviors). During a review of Resident 10's History and Physical (H&P), signed on 11/07/2025, the H&P indicated the resident was able to make decisions regarding activities of daily living. During a review of Resident 10's Order Summary Report dated 3/12/2026, the report indicated the following orders: Divalproex Sodium (used for treatment of manic episodes associated with bipolar disorder), delayedˆrelease oral tablet 375 mg, to be given by mouth twice a day for schizoaffective disorder bipolar type manifested by uncontrolled angry outbursts, with a start date of 12/09/2025. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Olanzapine 2.5 mg oral tablet, to be given by mouth at bedtime for psychosis in the setting of schizophrenia manifested by paranoid delusions that people are conspiring against him, with a start date of 12/09/2025. During a review of Resident 10's Psychotherapeutic Drug Informed Consent for Olanzapine 2.5 mg at bedtime for psychosis manifested by paranoid delusions, the prescriber signature area was blank, and the date area was blank. During a review of Resident 10's Psychotherapeutic Drug Informed Consent for Divalproex Sodium 375 mg by mouth twice daily for schizoaffective disorder manifested by aggressive behavior, the prescriber signature area was blank, and the date area was blank. During an interview and record review on 3/12/2026 at 4:40 PM with the Director of Nursing (DON), while reviewing Resident 10's consents for Divalproex Sodium and Olanzapine, the DON stated that per facility policy, the prescribing physician must sign and date psychotropic medication consents immediately upon obtaining consent from the resident or resident representative. The DON stated the consent is not valid unless it includes the prescriber's signature and date. 2.During a review of Resident 72's AR, the facility admitted Resident 72 on 2/18/2026 with diagnoses that included encephalopathy (any diffused disease of the brain that alters brain function or structure) and schizophrenia. During a review of Resident 72's HP, dated 2/20/2026, the HP indicated that Resident 72 had the capacity to make decisions for activities of daily living. During a review of Resident 72's Order Summary Report the order, dated 2/18/2026, indicated that Resident 72 was receiving Haloperidol Oral Tablet 10 mg with instructions to give 1 tablet by mouth three times a day for schizophrenia manifested by paranoid delusions leading to inability to cope with internal stimuli. During a review of Resident 72's Order Summary Report the order, dated 2/18/2026, indicated that Resident 72 was receiving Olanzapine Oral Tablet 20mg with instructions to give 1 tablet by mouth at bedtime for schizophrenia manifested by auditory hallucinations (perceptual experiences in the absence of real external sensory stimuli) of hearing voices telling him to harm himself responding to internal stimuli causing stress. During a review of Resident 72's Order Summary Report the order, dated 2/18/2026, indicated that Resident 72 was receiving Quetiapine Fumarate Oral Tablet 25mg with instructions to give 1 tablet by mouth two times a day for schizophrenia manifested by paranoid delusions (misconceptions or beliefs that are firmly held, contrary to reality) thinking people were whispering responding to internal stimuli causing angry outbursts. During a review of Resident 72's Order Summary Report the order, dated 2/18/2026, indicated that Resident 72 was receiving Quetiapine Fumarate Oral Tablet 50mg with instructions to give 1 tablet by mouth at bedtime for schizophrenia manifested by paranoid delusions of people whispering responding to internal stimuli causing angry outbursts. During a review of Resident 72's Minimal Data Set (MDS, a resident assessment), dated 2/25/2026, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the MDS indicated that Resident 72's cognitive (a person's thought process) skills were moderately impaired. The MDS indicated that Resident 72 did not experience any hallucinations or delusions. The MDS indicated that Resident 72 received antipsychotic medications on a routine basis. During a concurrent interview and record review on 3/12/2026 at 9 PM with the Director of Nursing (DON), Resident 72's informed consents for Haloperidol 10 mg, Olanzapine 20 mg, Quetiapine Fumarate 25 mg, and Quetiapine Fumarate 50 mg, all dated 2/18/2026, were reviewed .The DON stated none of the four informed consent forms had a physician's signature or date. The DON further stated the informed consent for Quetiapine Fumarate 50 mg did not contain documented evidence that the medication's probable side effects were explained to the resident or responsible party. During a continued interview and record review on 3/12/2026 at 9 PM, the DON stated the consents were prepared on 2/18/2026, and 22 days had passed without the required physician signatures. The DON stated it was important for the physician to sign the informed consent because the resident and responsible party have the right to be informed of the medication's purpose, potential side effects, and attempted nonˆpharmacological interventions before starting antipsychotic medications. 3.During a review of Resident 82's AR, the facility admitted Resident 82 on 9/20/2021 and readmitted Resident 82 on 3/6/2026 with diagnoses that included bipolar schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and dementia (a progressive state of decline in mental abilities). During a review of Resident 82's MDS, dated [DATE], the MDS indicated that Resident 82's cognitive skills were severely impaired. The MDS indicated that Resident 82 experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality). The MDS indicated that Resident 82 received antipsychotics and antidepressant medications on a routine basis. During a review of Resident 82's Order Summary Report the order, dated 3/6/2026, indicated that Resident 82 received Bupropion HCL Oral Tablet Extended Release 24 hours with instructions to give 150 mg by mouth one time a day for depression manifested by self-reported feelings of depression causing self-isolation. During a review of Resident 82's Order Summary Report the order, dated 3/6/2026, indicated that Resident 82 received Risperdal Oral Tablet 2mg with instructions to give 1 tablet by mouth two times a day for bipolar schizoaffective disorder manifested by poor reality orientation and negative thoughts due to internal stimuli. During a review of Resident 82's Order Summary Report the order, dated 3/6/2026, indicated that Resident 82 received Olanzapine (Zyprexa) Oral Tablet 10mg with instructions to give 1 tablet by mouth two times a day for bipolar schizoaffective manifested by hallucinations that people were against him causing angry outbursts. During a concurrent interview and record review on 3/13/2026 at 11:05 AM with the DON, Resident 82's Informed Consent for Bupropion HCL Oral Tablet Extended Release 150mg, Risperdal Oral Tablet 2mg, and Olanzapine (Zyprexa) Oral Tablet 10mg, dated 3/6/2026, were reviewed. The DON stated Resident 82's Representative Party (RP) signed Resident 82's antipsychotic informed consents on 3/6/2026 was not signed by the physician signature or date and the resident had been receiving the medications for 6 days. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) titled Psychotherapeutic Drug Informed Consent, dated January 2026, the P&P indicated that the informed consents were used to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, possible side effects, and alternative approaches before initiating the administration of psychotherapeutic drugs. The P&P indicated that the prescriber must provider the residents or their representatives with information such as the nature, degree, duration, and probability of the side effects and significant risks.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observations, interviews and record review, the facility failed to ensure that accurate and current nurse staffing data [total number and actual hours worked by licensed (Registered Nurses [RNs], License Vocational Nurses [LVNs]) and unlicensed nurses (Certified Nursing Assistant [CNAs])] were posted daily at the beginning of each shift (11 PM - 7 AM, 7 AM - 3 PM, and 3 PM - 11 PM). This deficient practice had the potential to delay recognition of inadequate staffing levels, which may lead to delayed response times, unmet resident needs, and decreased supervision, especially for residents requiring assistance with activities of daily living or safety monitoring. Furthermore, this deficient practice had the potential to impede residents, families, and visitors from accurately assessing staffing availability, which may hinder their ability to raise concerns, request assistance, or make informed decisions about the resident's care environment. Findings: Findings: During an observation on 3/10/2026 at 1:34 PM, a Census and Direct Care Service Hours per Patient Day (DHPPD-a CMSˆissued document used to record direct care service hours over a 24ˆhour period) dated 3/09/2026 (one day prior to the observation) was observed posted in the facility's front lobby. The document indicated the facility census was 78. The posted document did not include nursing staffing information by category of licensed and unlicensed staff (RNs, LVNs, CNAs, desk nurse, etc.) directly responsible for resident care for each shift (11 PM-7 AM, 7 AM-3 PM, 3 PM-11 PM). Instead, the posting showed projected nursing hours for licensed and unlicensed staff for 3/09/2026. The document did not list the actual hours worked for each category, type, or shift of nursing staff on 3/09/2026. During a concurrent interview and record review on 3/10/2026 at 1:34 PM with the Director of Nursing (DON), the DON stated the Director of Staff Development (DSD) was responsible for updating, posting, and filing the daily nurse staffing data in the facility's front lobby. The DON stated he had not noticed that the posting had not been updated that day. The DON stated the staffing posting should be updated daily at the beginning of the first shift. During an interview and record review on 3/10/2026 at 1:40 PM with the DSD, the DSD stated she was responsible for ensuring the daily posting of nurse staffing data was updated. The DSD stated she had been instructed upon hire to display the projected staffing hours in the facility lobby and not the actual hours worked for each shift. A review of the facility's Policy and Procedure (P&P) titled Posting Direct Care Daily Staffing Number, revised March 2023, indicated the following: At the beginning of each shift, the number of licensed nurses (RNs and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care shall be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The information recorded on the form shall include, among other details, The actual time worked during that shift for each category and type of nursing staff, and the total number of licensed and nonˆlicensed nursing staff working for the posted shift.

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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 and interview, the facility failed to ensure foods were properly stored and sealed in accordance with the facility's Policy and Procedure titled Food Receiving and Storage. This deficient practice had the potential to result in food contamination and the growth of microorganisms that could cause foodborne illness. Findings: During a concurrent initial kitchen observation and interview with the Dietary Supervisor (DS) on 3/10/2026 at 8:35 AM, Refrigerator #1 was observed containing an open plastic container with grape jelly that was not sealed, and a container of preserved fruit cocktail that was not sealed properly. The lid on the preserved fruit cocktail container had a visible crack approximately 1 inch in length. During the same interview, the DS stated she observed the open plastic container with grape jelly that was not sealed and the preserved fruit cocktail container that was not sealed properly. The DS stated the preserved fruit cocktail had to be thrown away because the cracked lid exposed the food to air, which could allow bacteria to enter. The DS stated all food products must be sealed and dated to prevent contamination and spoilage according to their policy. During a review of the facility's policy and procedure titled Food Receiving and Storage, revised 11/2022, the policy indicated foods shall be received and stored in a manner that complies with safe foodˆhandling practices, and that all foods stored in the refrigerator or freezer are to be covered, labeled, and dated (with a use by date).

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure advanced directives (ADs-written statements of a person's wishes regarding medical treatment, intended to guide care when the individual is unable to communicate) were obtained and accessible in the residents' medical records for two of two sampled residents (Residents 19 and 30). 1.Resident 19 and Resident 30's signed Advance Directive acknowledgment forms were not located in the residents' medical records. 2. Resident 30's Physician Orders for Life-Sustaining Treatment (POLST-medical order forms that direct medical staff regarding treatment preferences during a medical emergency when the individual cannot speak for themselves) were not completed in accordance with the facility's policy. This deficient practice had the potential to prevent residents' medical treatment preferences from being carried out during emergency situations and/or when a resident was incapacitated (unable to participate meaningfully in medical decisionˆmaking). Findings: During a review of Resident 30's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] with a diagnosis of motor vehicle accident with altered level of consciousness (not being able to understand or react normally) and traumatic brain injury (TBI - damage to the brain from an injury). During a review of Resident 30's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 2/25/2026, the assessment indicated Resident 30 had severely impaired cognition (thinking). During an interview on 3/11/2026 at 8:30 AM with the Social Services Designee (SSD), the SSD stated attempts were made to contact the Responsible Party (RP) following admission on [DATE] but were unsuccessful, and she could not recall why further attempts were not made. The SSD stated she had confirmed Family Member 2 (FM2) as the RP and reported that FM2 had a diagnosis of dementia. During a review of Resident 30's History and Physical (H&P), signed and dated 3/10/2026, the H&P indicated that Resident 30 was able to make decisions regarding activities of daily living (ADLs - basic activities required for care such as eating and bathing). During a concurrent record review on 3/11/2026 at 8 AM with the Business Office Manager (BOM), Resident 30's hard chart was reviewed. The BOM stated there was an issue identifying the RP. The BOM stated the facility attempted to contact FM2, identified as the RP, but was unsuccessful and left a message. The BOM stated Family Member 1 (FM1) declined the RP role and was listed as Emergency Contact #1. The BOM stated she was unable to explain why additional attempts to contact FM2 were not made. The BOM stated the hard chart did not contain the AD notification form or POLST, as these documents remained unsigned as of 3/10/2026. During a concurrent record review on 3/11/2026 at 8 AM with the SSD, Resident 30's hard chart was reviewed. The SSD confirmed the AD notification form and POLST were not present due to lack of signature and pending contact with the RP. The SSD stated she acknowledged these documents should be maintained in the medical record and that failure to obtain a completed POLST may delay medical interventions during a change in condition (a change in the resident's health). During a concurrent record review on 3/11/2026 at 9 AM with the Director of Nursing (DON), Resident 30's hard chart was reviewed. The DON stated that Resident 30's POLST was not in the chart and was not completed due to the inability to contact FM2. The DON stated a completed and signed POLST ensures Resident 30's medical wishes are known, including lifeˆsustaining treatments, resuscitation (DNR - Do Not Resuscitate vs. Full Code), hospital transfers, and other medical interventions. The DON stated that if a medical emergency occurs, staff can follow the resident's wishes immediately instead of guessing or delaying care. A review of the facility's P&P titled Advance Directives, revised 9/2022, indicated that advance care planning is a process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own decisions. The P&P indicated that the Physician Orders for Life-Sustaining Treatment (POLST) paradigm provides (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	improved patient care by creating a portable medical order form that records the patient's wishes so emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. The P&P indicated that if the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative. If the resident later becomes able to receive and understand this information, he or she will be provided with the same written materials, even if the legal representative has already received them.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and closed record review, the facility failed to ensure the required Notice of Proposed Transfer/Discharge (a written notification to the resident or responsible party (RP) that included the reason for the transfer or discharge) was sent to the Longˆ Term Care Ombudsman (an state agency that advocates for the residents) for one of two sampled residents (Resident 91). The facility did not inform or email the Ombudsman office when Resident 91 was discharged from the facility, This deficient practice violated the resident's rights to have the Long-Term Care Ombudsman (advocates for residents of nursing homes, board and care homes and assisted living facilities) to advocate for Resident 91's transfer or discharge home. Findings: During a review of Resident 91's admission Recordˆ(AC), the ACˆindicatedˆthe resident was originally admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a long-term lung condition that makes it progressively harder to breathe), schizoaffective disorder (a chronic mental illness that causes a person to experience dramatic changes in their thoughts, moods, and behaviors). During a review of Resident 91's Order Summary Report dated 3/12/2026, the Order Summary Report indicated Resident 91 discharged home with resident's Family 1 (FMA)1 with all her medications and belongings and home health follow up with primary physician and psychiatrist with an order date of 1/20/2025. During an interview and record review on 3/12/2026 at 1:10 PM with Medical Record Director (MRD) of Resident 91's Notice of Transfer/discharge date d 1/20/2026 , MRD stated when a resident was transferred or discharged the facility must send a copy of the Transfer/ Discharge form to the ombudsman and keep a copy of the fax confirmation as part of their medical records. MRD stated he did not send the Ombudsman a copy of Resident 91's Transfer/Discharge Notice. During an interview on 3/12/2026 4:50 PM with Director of Nursing (DON), the DON stated it is facility policy to send the Ombudsman a copy of a Residents Transfer or Discharge notice to ensure they are informed of the facility residents who are being transferred and discharged . During a review of the facility's policy and procedure (P&P) titled Transfer or Discharge Notice, dated with a revision March, 2025, the P&P indicated A copy of the notice is sent to the office of the State Long Term Care Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative.

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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 interview and record review, the facility failed to ensure one of three sample residents (Resident 90) was provided with care and treatment in accordance with professional standards of practice by failing to: 1. Implement the Discharge Summary instructions from the General Acute Care Hospital (GACH) 1, dated 12/25/2025 to follow up with the outpatient cardiology to consider resuming beta blocker (medications that decrease heart rate and blood pressure) given Resident 90 had episodes of bradycardia (slow heart rate less than 60 beats per minute) and for placement of Zio Patch monitor (a water-resistant monitor applied to the upper left chest allowing continuous heart rhythm [heart electrical activity measuring the heart rate and any abnormal activity] monitoring with optional symptom logging monitor) 2. Implement interventions for Resident 90's complex medical history related to Coronary Artery Disease (CAD, plaque buildup in arteries [long tubes that transport oxygen and blood to the body]) and bradycardia (slow resting heart rate, less than 60 beats per minute [bpm]; normal heart rate 60 - 100 bpm) HR 20's and refusal of medications at times. 3. Follow up and monitor on Resident 90's Change of Condition (CoC) on 1/5/2026 after Resident 90 had 1 episode of watery colored emesis (vomiting) at 12:30 PM. These failures resulted in the lack of monitoring, medical management, and coordination of Resident 90's overall treatment related to his cardiac history of CHF and episodes of bradycardia.Findings: During a review of Resident 90's admission Record (AR), the facility admitted Resident 90 on 10/6/2025 and readmitted Resident 90 on 12/30/2025 with diagnoses that included Acute Respiratory Failure (ARF, the lungs cannot get enough oxygen into the blood) with hypoxia (not enough oxygen in blood), bradycardia (slow heart rate less than 60 beats/minute) and bipolar schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 90's Minimal Data Set (MDS, a resident assessment), dated 10/13/2025, Resident 90's cognitive (a resident's thought process) skills were moderately impaired that needed moderate assistance (helper does less than half the effort) for ADLs such as toileting, showering, and dressing and needed supervision when transferring from a lying to sitting position in bed. During a review of Resident 90's Change of Condition (CoC) evaluation record, dated 12/21/2025 timed at 12:11 PM, the CoC record indicated at 11: 45 AM Resident 90 was in the dining room, hunched over with eyes closed. The record indicated Resident 90 was nonresponsive and passed out, and a staff member assisted Resident 90 to the floor. The record indicated the facility called 911, and Resident 90 was transferred to GACH 1. During a review of History and Physical record from GACH 1, dated 12/21/2025 timed at 9:23 PM, indicated Resident 90 had CHF and an exacerbation of COPD. During a review of GACH 1's Inpatient Progress Note dated 12/23/2025 timed at 6:45 AM, it indicated that Resident 90 had one episode of bradycardia with a heart rate of 20s while on the way to the Emergency Department. The record indicated that Resident 90 had another episode bradycardia with a heart rate of 20s but returned to normal without interventions. During a review of Inpatient Progress Note record, dated 12/25/2025 timed at 11:13 AM, the record indicated that Resident 90 ECHO (Echocardiogram, ultrasound to show how blood flows through the heart) test result on 12/22/2025, indicated Resident 90's Ejection fraction (EF is a percentage measuring how well the left ventricle pumps blood with each heartbeat, with a normal range typically 50%-70%) a low EF signifies that the heart is not pumping efficiently, which can indicate heart failure, reduced exercise capacity, and symptoms like fatigue and shortness of breath) low at was 32%. During a review of Resident 90's GACH 1 Discharge Summary record, dated 12/25/2025, the record indicated the following outpatient follow up and discharge plans To follow up with the outpatient cardiology to consider resuming beta blocker medication given Resident 90 had episodes of bradycardia and for placement of Ziopatch monitor outpatient. During a review of SNF 1's Nursing Advance Clinical Admission record, dated 12/26/2026 timed at 7 PM, the record indicated Resident 90 was admitted to SNF 1 from GACH 1 alert and oriented but sometimes forgetful, with regular heart rate, and receiving (continued on next page)

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	555755	A. Building B. Wing	03/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Green Acres Healthcare Center	8101 E Hill Drive Rosemead, CA 91770

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen via nasal cannula (flexible thin tube used to deliver oxygen). The record indicated that Physician 1 was notified on 12/26/2026 of Resident 90's medication reconciliation, assessment findings, and admission to SNF 1. During a review of Resident 90's Nursing Advance Clinical Admission record, dated 12/30/2025 timed at 5 PM, the record indicated that Resident 90 was transferred to the facility from SNF 1 at 5 PM via private transport in a wheelchair. The record indicated that Physician 1 was notified of Resident 90's readmission to the facility from SNF 1 and will continue with all discharge/hospital orders and or treatments. During a review of Resident 90's CoC Evaluation record, dated 1/5/2026 timed at 12:30 PM, the record indicated that Resident 90 had one episode of water colored emesis. The record indicated thatPhysician 1 was notified of Resident 90's emesis and indicated the following order if emesis persists send out to [Emergency Room] for further treatment and evaluation. During an interview on 3/11/2026 at 2:28 PM with Physician 1 (Attending Physician), Physician 1 stated he saw Resident 90 after he was readmitted back to the facility on [DATE], but Physician 1 stated I do not remember if [Resident 90] refused treatments or not. Physician 1 indicated that he was aware Resident had one episode of watery emesis on 1/5/2026 before he passed away, but Physician 1 stated he cannot remember if he gave any specific orders. During a review of Fire Department Incident report, dated 1/6/2026 timed at 7:30 AM, the report indicated that Resident 90 complained of heart burn (burning sensation in the chest or throat caused by stomach acid reflux back into the esophagus) prior to cardiac arrest (abrupt loss of heart function) and the initial heart rhythm was asystole (heart completely stops working, resulting in no heartbeat, pulse, or blood circulation). The report indicated that Resident 90's time of death was 1/6/2026 at 7:58 AM. During the same concurrent interview and record review on 3/11/2026 at 4:20 PM with the DON, Resident 90's care plans were reviewed. The DON stated there was no documented evidence of any care plan related to Resident 90's cardiac medical history related to bradycardia. The DON stated there was no documented evidence of any care plan related to Resident 90's refusals of treatments. The DON stated it was important to create a care plan for Resident 90's cardiac diagnoses to implement specific monitoring related to Resident 90's heart rate and blood pressure. During the same concurrent interview and record review on 3/11/2026 at 4:35 PM with the DON, Resident 90's CoC Evaluation record dated 1/5/2026 timed at 12:30 PM, Progress Notes and Licensed Nurses Notes, were reviewed. The DON stated, the record indicated that Physician 1 was notified of Resident 90's CoC and to continue monitoring Resident 90 for continuous emesis. The DON stated that the Licensed Nurses were expected to document their continued monitoring of Resident 90's continuous emesis in the Licensed Nurses Note. The DON stated, there was no documented evidence in the Progress Notes and Licensed Nurses Notes for Resident 90's continued monitoring for emesis. During the same concurrent interview and record review on 3/11/2026 at 4:55 PM with LVN 2, Resident 90's MAR for January 2026, was reviewed. LVN 4 stated, she checked Resident 90's vital sign once a shift. LVN 4 stated, Resident 90's baseline heart rate was 75 - 80 bpm. LVN 4 stated Resident 90 did not have a specific order for heart rate monitoring. During the same interview on 3/11/2026 at 5 PM with LVN 2, LVN 2 stated she worked on 1/5/2026. LVN 4 stated, it was endorsed to her that Resident 90 had one episode of emesis in the previous shift, but she did not know if there was any specific monitoring related to Resident 90's CoC on 1/5/2026. During a concurrent interview and record review on 3/11/2026 at 5:15 PM with the DON, Resident 90's GACH 1 Discharge Summary record, dated 12/25/2026, was reviewed. The DON stated, Resident 90's discharge instructions included to follow up with the outpatient cardiology consultation regarding Resident 90's medications for CHF outpatient heart rate monitoring, and to continue his breathing treatments twice a day. The DON stated there was no cardiac consultation order and no documentation that Physician 1 was notified of Resident 90's GACH 1 Discharge instructions. The DON stated, I missed the outpatient follow up discharge orders from the [GACH] for outpatient cardiac follow up. During an interview on 3/12/2026 at 4:40 PM with Physician 1, Physician 1 stated it was the physician's responsibility to review the transfer papers from the GACH or outside facility and medications. Physician 1 stated he was Resident 90's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitting physician at the facility not at SNF 1. Physician 1 stated, he received a call readmitting Resident 90 back at the facility and agreed to continue all the medications from SNF 1. Physician 1 stated, he saw Resident 90 on 12/31/2025 and reviewed Resident 90's clinical records including all his transfer documents such the GACH 1 discharge instructions but did not see the record indicating the referral for Cardiology for heart monitoring and medication regimen for CHF. Physician 1 stated the licensed staff did not inform him about the GACH 1's referral of the resident to Cardiology for heart monitoring and CHF treatments. During a concurrent interview and record review on 3/13/2026 at 2:33 PM with LVN 2, Resident 90's Licensed Nursing Notes, were reviewed. LVN 2 stated Resident 90 was readmitted to the facility on [DATE] and remembered on admission, Resident 90 was out of breath upon when being transferred via wheelchair and. LVN 2 stated, she worked from 2 PM to 2 AM, and Resident 90 appeared comfortable and did not complain of shortness of breath. LVN 2 stated, she forgot to do a Licensed Nurses Note for the afternoon shift on 1/5/2026. During a review of the facility's policies and procedures (P&P) titled Change of Condition, date unknown, the P&P indicated that the purpose of a change of condition was to ensure proper assessment and follow-through for any resident with a change of condition. The P&P indicated that change of condition included but not limited to a sudden or marked difference in resident's vital signs, behavior, complaints, and chest condition or shortness of breathing. During a review of the facility's P&P titled Notification of Physician, date unknown, the P&P indicated that the Attending Physician/Alternate will be notified when there is a change in condition. The P&P indicated that the Licensed Nurse will subsequently note and carry out the physician's orders. During a review of the facility's P&P titled Admission/Readmission, dated March 2025, the P&P indicated that the physician and the care planning team will conduct a comprehensive assessment and develop a more detailed interdisciplinary care plan.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a medication error rate less than five (5) percent (%) during medication pass by committing two (2) medication errors on one of five sampled residents (Resident 8) during medication observation with 29 medication opportunities that resulted in a 6.9% medication error rate. This deficient practice had the potential to result in adverse reactions (undesired effect of a drug or other type of treatment), ineffective treatment, worsening of the resident's condition, or potentially serious harm, injury, or death. Exceeding the acceptable error rate indicates a systemic issue in safe medication administration. Findings: During a review of Resident 8's admission Recordˆ(AC), the ACˆindicatedˆthe resident was originally admitted to the facility on [DATE] and most recently re-admitted on [DATE] with diagnoses that included Type 2ˆDiabetes Mellitus (blood sugar levels in the blood are higher than normal) andˆhyperlipidemia (a condition where you have too many fats in your blood). During a review of Resident 8's History and Physicalˆ(H&P) signed on 1/2026, the H&Pˆindicatedˆthe residentˆdoes not have the capacity to understand and make decisions.ˆˆ During a review of Resident 8's Order Summary Report dated 3/12/2026, the Order Summary Report indicated a medication order for: 1.Metoprolol tartrate (a medication used to treat high blood pressure and control heart rate) oral tablet 25 milligrams (mg-a unit of measurement), give one tablet by mouth one time a day for hypertension. Give with food to minimize risk of orthostatic hypotension (a sudden drop in blood pressure that occurs upon standing from a sitting or lying position). 2. Metformin HCL (medication used to treat high blood sugar) oral tablet 1000 mg, one tablet by mouth two times a day for Diabetes Mellitus, administer with food. During a medication pass observation on 3/12/2026 at 8:18 AM with Licensed Vocational Nurse (LVN 1), LVN 1 was observed administering Metoprolol tartrate oral tablet and Metformin HCL oral tablet to Resident 8 with water without food. Then LVN 1walked back to her medication cart to document in Resident 8's medication administration record. During a concurrent interview and record review with LVN 1 on 3/12/2026 at 8:22 AM, LVN 1 stated she was aware Resident 8's Metformin and Metoprolol medications indicated to administer each medication with food but she assumed it was ok not to give food right now with the medication since Resident 8 had had breakfast around 7AM. During an interview and record review on 3/12/2026 at 10:01 AM with Director of Nursing (DON), The DON stated Resident 8's medication order indicates to administer Metformin and Metoprolol medications with food. DON stated LVN 1 should have given Resident 8 a cracker or cookie if it is not mealtime and not administer the medication without food. The DON stated all licensed nurses administering medication should follow the doctors orders to prevent any undesired side effects in this case for Resident 8 stomach upset or orthostatic hypotension. During a review of the facility's policy and procedure (P&P) titled Med Pass, undated, the P&P indicated prepare the med correctly, administer the med correctly and chart the med pass correctly.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, the facility failed to ensure medications were not expired prior to administration for 1 out of 3 sampled residents (Resident 83). An observation of the locked medication refrigerator revealed an expired ABH gel (a compounded topical medication containing Ativan [medication for anxiety], Benadryl [antihistamine], and Haldol [antipsychotic medication]) 1mg-25mg-1mg/1ml with an expiration date of 2/25/2026. Record review indicated the expired medication was administered to Resident 83 seven times over a fiveˆday period. This deficient practice had the potential to affect Resident 83 and other residents receiving medications from improperly monitored storage. Findings: During a review of Resident 83's admission Record (AR), the AR indicated the resident was readmitted to the facility on [DATE] with diagnoses of unspecified dementia and mood disorder. During a review of Resident 83's History and Physical (H&P), signed and dated 12/18/2025, the H&P indicated Resident 83 did not have the capacity to understand and make decisions. During a review of Resident 83's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 83 had severely impaired cognition. During a review of Resident 83's Telephone Order dated 1/18/2026, the order indicated ABH Topical Gel (Ativan 1 mg, Benadryl 25 mg, Haldol 1 mg/1 ml) was to be applied every 4 hours as needed for agitation/restlessness, rubbed topically to the inner wrist alternating between right and left, and gloves were to be worn. During a review of Resident 83's Medication Administration Record (MAR) dated 02/2026, the MAR indicated that Resident 83 was administered ABH topical gel on 2/27/2026 at 6:45 AM. During a review of Resident 83's MAR dated 03/2026, the MAR indicated that Resident 83 was administered ABH topical gel on: 3/3/2026 at 7 PM 3/3/2026 at 11:15 PM 3/4/2026 at 7:06 AM 3/6/2026 at 6:40 AM 3/9/2026 at 6:30 AM 3/11/2026 at 6:31 AM During a medication storage observation and interview with the Director of Staff Development (DSD) and Licensed Vocational Nurse (LVN 1) on 3/11/2026 at 1:15 PM, the locked medication refrigerator contained three prefilled 10 ml syringes of ABH Gel (Ativan 1 mg - Benadryl 25 mg - Haldol 1 mg/ml) with an expiration date of 2/25/2026. The DSD and LVN 1 both stated they observed the expired medication. LVN 1 stated that administering expired medication could result in ineffective treatment due to decreased potency. During an interview on 3/11/2026 at 1:30 PM, the DSD stated that expired ABH topical gel could lose potency and may not work as intended. The DSD stated that expired medications should be identified and removed from storage promptly. During a concurrent record review on 3/11/2026 at 2:05 PM, the DSD stated that Resident 83 had received an expired dose of ABH topical gel on 2/27/2026 at 6:45 AM. During a concurrent record review on 3/11/2026 at 2:10 PM, the DSD stated that Resident 83 received ABH topical gel on 3/3/2026 at 7 PM, 3/3/2026 at 11:15 PM, 3/4/2026 at 7:06 AM, 3/6/2026 at 6:40 AM, 3/9/2026 at 6:30 AM, and 3/11/2026 at 6:31 AM, and stated the licensed nurse should have checked the expiration date prior to administration. The DSD stated that expired medications should be removed from stock prior to expiration and that nursing staff are responsible for ensuring medications are current and safe before administration. During an interview on 3/11/2026 at 2:38 PM, the Director of Nursing (DON) stated he acknowledged that Resident 83 received expired ABH topical gel and stated that nursing staff are responsible for verifying expiration dates and removing expired medications from storage. During a review of the facility's policy and procedure titled Medication Storage in the Facility, dated 3/2008, the policy indicated that outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are to be removed from stock immediately and disposed of according to procedures. During a review of the facility's policy and procedure titled Med Pass, undated, the policy indicated that medications are not to be administered based on memory and are not to be administered solely because they are available.