

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555785	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Courtyard Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1880 Dawson Avenue Signal Hill, CA 90806	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review the facility's Quality Assurance and Performance Improvement (QAPI) Committee (group responsible for identifying and responding to quality deficiencies in the facility), the facility failed to implement the action plan for the performance improvement project (structured efforts to systematically identify and resolve issues) regarding staff call light response for 56 out of 56 residents. The deficient practice placed the residents at risk for not receiving the quality treatment necessary to adequately meet their highest practicable well-being. Findings: During a record review of the facility's QAPI plan, initiated 8/1/2025, the plan indicated that the facility's call light response was a system issue and an area of improvement. The QAPI's Program action plan indicated that the Administrator (ADM) and managers will ask residents about call light response to measure performance improvement. During a concurrent interview and record review on 12/12/2025 at 9:24 a.m., with the ADM, the facility Angel Daily Room Rounds were reviewed. The ADM stated the rounds did not indicate the staff interviews of residents regarding call light response. The ADM stated there was no documented evidence of interviews conducted that will measure performance improvement. The ADM stated there were missing elements of the project that indicate QAPI program was being implemented. During a record review of the facility's policy and procedure (P&P) titled, Quality assurance performance Improvement Program, revised 2/2022, the P&P indicated the QAPI committee will address specific care and quality issues and implement actions plan to resolve these issues. The P&P indicated the following: 1) QAPI Program is focused on indicators of the outcomes of care and quality of life for our residents. 2) The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of this process include: a. Tracking and measuring performance. b. Establishing goals and thresholds for performance measurement. c. Systematically analyzing underlying causes of systemic quality deficiencies. d. Implementing corrective action. e. Monitoring or evaluating the effectiveness of corrective action/performance improvement activities and revising as needed. f. The committee meets to review reports, evaluate data, and monitor results and adjust the plan.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and record review the facility failed to develop and implement a Water Management Plan (plan that identifies hazardous conditions and steps to take to minimize the growth and spread of bacteria[germs]) for 56 out of 56 residents. This deficient practice had the potential to expose residents and staff to Legionella (bacteria that can cause serious lung infections) resulting in pneumonia (lung infection), hospitalization or even death. Findings: During an interview on 12/10/2025 at 9 a.m., with the Maintenance Supervisor (MS), the MS stated he just measures water temperatures, makes sure the ice machine was clean, and there were no other tasks regarding the water management plan. During a concurrent interview and record review on 12/10/2025 at 9 a.m., with the Infection Prevention Nurse (IPN), the facility's water management plan was reviewed. The IPN stated there were missing elements to the water management plan. During an interview on 12/10/2025 at 11 a.m. with the Administrator (ADM) the ADM stated the facility should complete the water management assessment because it was required. The ADM stated the water management had no control measures (things you do in the building water systems to limit growth and spread of legionella such as heating, adding disinfectant or cleaning) applied and how to monitor them, there were no interventions created if control measures were not met, there was no documentation of all the activities of the program. During a review of the facility's policy and procedure (P&P) titled, Legionella Water Management Program, revised 7/2017, the P&P indicated water management plan will have the following elements: a. An interdisciplinary water management team. b. A detailed description and diagram of the water system in the facility, including the following:(1) Receiving (where water enters)(2) Cold water distribution (where does cold water go)(3) Heating.(4) Hot water distribution; and(5) Waste (where waste is discarded) c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including:(1) Storage tanks.(2) Water heaters.(3) Filters.(4) Aerators (device attached to faucet)(5) Showerheads and hoses.(6) Misters (fire suppression systems that use very small water droplets to extinguish or control fires), atomizers (device changes water to mist), air washers (air purification), and humidifiers (device adds moisture to air).(7) Hot tubs.(8) Fountains; and(9) Medical devices such as CPAP machines (Continuous Positive Airway Pressure machine that treats breathing problems), etc. d. The identification of situations that can lead to Legionella growth, such as:(1) Construction(2) Water main breaks(3) Changes in municipal water quality (4) The presence of biofilm or slime (Germs and the slime they secrete that stick to and grow on any continually moist surface provides housing, food, and security for many different types of germs, including Legionella), (5) scale or sediment (the mineral build-up in a water system that uses up disinfectants and supports germ growth and/or survival)(6) Water temperature fluctuations(7) Water pressure changes(8) Water stagnation (When water does not flow well; areas of stagnant water encourage biofilm growth and reduce temperature and level of disinfectant)(9) inadequate disinfection. e. Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants).f. The control limits or parameters that are acceptable and that are monitored.g. A diagram of where control measures are applied.h. A system to monitor control limits and the effectiveness of control measures.i. A plan for when control limits are not met and/or control measures are not effective; andj. Documentation of the program. The P&P indicated the Water Management Program will be reviewed at least once a year, or sooner if any of the following occur:a. The control limits are consistently not met.b. There is a major maintenance or water service change.c. There are any disease cases associated with the water system; ord. There are changes in laws, regulations, standards or guidelines.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure Licensed Vocational Nurse (LVN) 1 administered two medications for one of two resident (Resident 15) with food as ordered by the physician. This resulted in the medication administration error rate of 7.41percent.Findings:During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE] with diagnosis including Diabetes Mellitus ([DM])a disorder characterized by difficulty in blood sugar control), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and gout (a painful inflammatory arthritis).During a review of Resident 15's Minimum Data Set ([MDS] a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 15 had intact cognition (ability to think and reason) and needed set up assistance with eating.During a review of Resident 15's Order Summary report, starting 11/14/2024, the order indicated:1) Indomethacin Oral Capsule (medication for gout) 25 milligrams (mg), one capsule by mouth two times a day with instructions to take with food. 2) Metformin Oral Tablet (medication for DM) 500 mg, one tablet by mouth two times a day with instructions to take with food. During a concurrent observation and interview on 12/9/2025 at 8:45 a.m., LVN 1 administered Indomethacin and Metformin to Resident 15 and LVN 1 stated Resident 15 had breakfast earlier because there was no more breakfast tray at the bedside and the medications were not administered with food.During an interview on 12/9/2025 at 8:50 a.m., with Resident 15, Resident 15 stated she finished eating breakfast at 7:40 a.m.During an interview with the Director of Nursing (DON) on 12/12/2025 at 7:55 a.m. the DON stated medication error rate needs to be no greater than 5 percent. [KB1] The DON stated if the instructions indicate to give with food, then the medication needs to be administered with food otherwise it was an error. During a review of the facility's Policy and Procedure (P/P) titled, Medication-Administration, revised 12/2024, the P/P indicated the P/P was to ensure safe, timely medication administration as ordered.Cross reference: F755		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: a. Ensure the opened UTI -Stat (supplement support urinary health) bottle used for one of one resident (Resident 15) was labeled with an open date. b. Ensure the insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) pen for one of five residents (Resident 10) was labeled with an open date and expiration date. c. Ensure an open bottle of Multivitamins with minerals (supplement) for one of two residents (Resident 24) was labeled with an open date These deficient practices had the potential to result in medication errors. Findings: a. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE] with diagnosis including Diabetes Mellitus ([DM]a disorder characterized by difficulty in blood sugar control), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and gout (a painful inflammatory arthritis). During a review of Resident 15's Minimum Data Set ([MDS] a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 15 had intact cognition (ability to think and reason) and needed assistance with eating. During a review of Resident 15's Order Summary report, starting 1/2/2025, the order indicated UTI-Stat Oral Liquid administer 30 milliliters (ml) by mouth one time a day. During a concurrent observation and interview on 12/9/2025 at 8:45 a.m., Licensed Vocational Nurse (LVN) 1 was preparing Resident 15's UTI-Stat medication and LVN 1 stated there was no open date for the already opened UTI-Stat supplement. During a concurrent interview and record review 12/9/2025 at 8:47 a.m., with LVN 1, the UTI-Stat label was reviewed and the label indicated to discard after 3 months of opening. LVN 1 stated that the bottle need an open date so we can discard it after three months of opening. b. During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] with diagnosis including DM. During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 had severely impaired cognition and Resident was dependent (helper does all the effort) on staff for all Activities of Daily Living ([ADLs] activities such as bathing, dressing and toileting a person performs daily) During a review of Resident 10's Order Summary report, starting 11/30/2025, the order indicated Lantus SoloStar 100 unit/ milliliter Solution Pen-Injector (medication that treats DM), inject 12 units subcutaneously (under the skin) two times a day. During a concurrent observation and interview on 12/10/2025 at 8:44 a.m., with the Registered Nurse Supervisor (RNS) of the medication cart for station 1, Resident 10's Lantus SoloStar pen-Injector was reviewed. The Lantus SoloStar pen-Injector was not dated and labeled with the new expiration date. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The RNS stated the medication needed the date it was opened because it is only good for a prescribed time frame. During a review of the Lantus Prescribing information handout, revised 5/2025, the handout indicated that the insulin pen was good for 28 days after opening and stored at room temperature. During an interview on 12/12/2025 at 7:55 a.m. with the Director of Nursing (DON), the DON stated medications should be stored separately and need the date open indicated in the multi-use bottles or containers for residents' safety. c. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities). During a review of Resident 24's H&P dated 10/17/2025, the H&P indicated Resident 24 did not have the capacity to understand and make decisions. During a review of Resident 24's MDS dated [DATE], the MDS indicated Resident 24 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment and was dependent when eating, oral hygiene, upper and lower body dressing, toileting hygiene, and bathing. During a review of Resident 24's Physician Order Summary dated 12/12/2025, the Order Summary indicated an order for multivitamin with minerals give one time a day for supplement. During a concurrent observation and interview on 12/11/2025 at 9:15 a.m. with LVN 4, LVN 4 was observed preparing medications for Resident 24. The multivitamin with minerals medication was observed with no open date indicating when the medication was opened. LVN 4 stated the multivitamin with minerals medication is not labeled with an open date, and medications should be labeled with an open date. During an interview on 12/12/2025 at 7:55 a.m. with the Director of Nursing (DON), the DON stated medications should be stored separately and need the date open indicated in the multi-use bottles or containers for residents' safety. During a review of the facility's P&P titled, Medication Storage in the Facility, revised 5/2022, the P&P indicated medications were stored following manufacturer's recommendations. The P&P indicted when the original seal of manufacturer's container is initially broken the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. During a review of the facility's P&P titled, Administering Medication, revised 12/2024, the P&P indicated when opening a multidose container, the date opened shall be recorded in the container.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to food was stored in a sanitary manner to prevent growth of microorganisms that could cause food borne illness (food poisoning: any illness resulting from food spoilage or contaminated food) for 56 out of 59 residents by failing to:1. Discard unknown resident's tray that had once left the kitchen.2. Date and label frozen items, produce, and stored goods. 3. Discard expired food items in the dry storage.4. Remove wristwatch while being in the kitchen. 5. Implement safe food handling and sanitation.6. Properly perform hand hygiene and wear gloves when handling the thermometer. These deficient practices had the potential to result in residents being exposed to germs and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization. During an initial kitchen tour and interview on 12/9/2025 at 8:36 a.m., with [NAME] (CK) 1, CK 1 stated brown bag with date 12/8/2025, and no residents name on it, in the refrigerator was for a resident (unknown) that goes to dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). There was a plate with a lid on it in the kitchen refrigerator, and it was observed with no resident identifier or date. CK 1 stated the plate with the lid is a fruit plate, and indicated that plate was a resident's (unknown) plate that was sent given to the resident, and was placed back into the refrigerator since the resident (unknown) wanted to eat the fruit plate around later. During a concurrent observation and interview on 12/9/2025 at 8:42 a.m., with CK 1, CK 1 stated the unopened small milk cartons and the container with individual pats of butter, did not have a received on date. During a concurrent observation and interview on 12/9/2025 at 8:59 a.m., with the Dietary Supervisor (DS), the DS stated in the dry storage area: There were no dates on six tapioca mix bags, Cinnamon Streusel, one box of tea bags, a box of iced tea mix and a container of packets of relish. A container of dry peas, and a box of dry lentils were dated 5/11/2023 Two panko bags labeled with an expiration date of 7/9/2025. The lids of the brown rice tub and white rice tub were switched and were not dated. During a concurrent observation and interview on 12/9/2025 at 9:29 a.m., with the DS, of the freezer, the DS stated One Chef [NAME] pumpkin pie with no box was not dated. Two chocolate flavored cream pies with no box were not dated. A bag of tatter tots was not dated. A bag of meatballs was not dated and An opened bag of barbeque pork rib patty had no open date. During a concurrent interview and record review on 12/9/2025 at 9:49 a.m., with the DS, the DS stated the date is required to know when the items came in and to calculate the use by date. The DS stated if the food items were undated, they will not know when the food item expires and the residents may get sick. The DS stated they should not have any expired items in the dry storage and freezer, and should be tossed if they are expired. The DS stated on the guidelines they utilize (Dietary Directions, Inc./Nutrition Therapy Essentials, Inc. Food Service Policy and Procedures Manual 2018), dry beans are good for one year and indicated the dried peas and lentils are both expired. During a concurrent observation of pureeing (blended food so it does not require chewing) food items and interview on 12/10/2025 at 11:33 a.m., with [NAME] (CK 2) 2, CK 2 was observed preparing a pureed version of seasoned white beans with ham, and wiping his hands on his clothing. CK 2 was observed storing three black plastic spoons in the upper left arm pocket and handed me a spoon from the said pocket from his arm. CK 2 was observed moving onto the next task (pureeing seas greens) after pureeing the seasons beans with ham without performing hand hygiene. CK 2 stated hand washing between tasks was done to prevent contamination as the residents can get sick from cross contamination. During an observation on 12/10/2025 at 11:44 a.m., in the kitchen, the DS was observed wearing a watch that was directly touching/rubbing against the top counter area of where the hot foods were stored to keep warm. During a concurrent observation during food temperature check and interview on (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/10/2025 at 11:46 a.m., with CK 2, CK 2 was going to start doing temperature checks without performing hand hygiene. CK 2 stated after pureeing the corn bread (task after pureeing seas greens), he did not wash his hands and indicated he was supposed to wash his hands. CK 2 stated gloves are worn when you touch food and prepare other food to avoid contamination. CK 2 was observed doing the following preparation to take the temperature of the food items: Wore a glove on the left hand, held the thermometer in the gloved left hand, and with the non-gloved right hand grabbed a few alcohol wipes. With the non-gloved right hand, CK 2 opened the alcohol wipe, proceeded to wipe the thermometer with the non-gloved right hand, and stuck the thermometer in the seasoned beans and ham with the gloved left hand. CK 2 grabbed a new alcohol wipe with the non-gloved right hand, cleaned the thermometer with the non-gloved right hand, and proceeded to put the thermometer with the gloved left hand into the potatoes. CK 2 grabbed the used alcohol wipe that was previously used to clean the thermometer before putting it into the potatoes with the non-gloved right hand, proceeded to clean the thermometer with the non-gloved right hand, and placed the thermometer into the seas greens with the gloved left hand. CK 2 grabbed a new alcohol wipe with the non-gloved right hand, cleaned the thermometer with the non-gloved right hand, and proceeded to put the thermometer with the gloved left hand into the corn bread. During a concurrent observation and interview on 12/10/2025 at 12:19 p.m. with the DS, the DS stated dietary staff were not supposed to wear jewelry and indicated she had a watch on and should not be wearing it as particles can fall into the food. The DS stated hand washing should be done as much as possible, when removing gloves, touching something, and before picking something up. The DS stated spoons should not be kept in the upper arm pocket due to cross contamination. The DS stated when checking the temperature of foods, the staff is supposed to have gloves on both hands and should be wearing gloves when they open the alcohol wipes to sanitize the thermometer. The DS stated with the thermometer should be cleaned each time the temperature is being taken. During an interview on 12/11/2025 at 2:11p.m. with the DS, the DS stated if a tray goes out to the resident, even if the resident does not touch the tray, the items that were on the tray cannot go back into the fridge. During an interview on 12/11/2025 at 2:54p.m. with the Director of Nursing (DON), the DON stated hand hygiene is done before doing a procedure, before putting and after removing gloves, or when handling food before and after. The DON stated hand hygiene is done to prevent the spread of infection and hands should be completely dry. The DON stated if your hands were wet, you do not wipe your hands on clothes as the clothes might have unwanted bacteria, before putting and after removing gloves. The DON stated the lids of the trash should be closed to prevent unwanted flies and smell. The DON stated food items should be dated as you want to make sure that the food is stored during the appropriate duration of time and expired food should not be left as it can put the resident's health at risk. During a review of the facility's Policy and Procedure (P&P), titled Labeling/Date Marking and Safe Storage of Refrigerated & Frozen Foods revised date 1/1/2018, the P&P indicated any foods removed from original container will be properly labeled as follows: the name of the food item being stored and the date the food was removed from its original container and stored. During a review of the facility's P&P Introduction to the Food & Nutrition Services Department (FNS) undated, the P&P indicated proper sanitation shall be maintained during all stages of food delivery, storage, preparation, and service. During a review of the facility's P&P Dietary Directions, Inc. / Nutrition therapy Essentials, Inc. Food Service Policy and Procedures Manual dated 2018, the P&P indicated under miscellaneous, dry beans are good for 1 year. During a review of the facility's P&P Hand washing undated, the P&P indicated each employee will wash his or her hands frequently to eliminate visible dirt and reduce the bacterial load. When to wash: After touching hands to the face, hair, or clothing, between working with raw foods and ready to eat foods, after working with or cleaning dirty equipment or utensils, between glove changes, between any dirty to clean task. During a review of the facility's P&P Safety and Sanitation undated, the P&P indicated Food & Nutrition Services employees shall perform job responsibilities in a safe and sanitary manner. Employees are not allowed to bring personal items including but not limited to cell phones, purses, make-up bags, etc., into the food service production areas.		

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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 record review, the facility failed to dispose of garbage and recyclables properly by not completely covering two of two trash dumpsters (a large trash container designed to be emptied into a truck). This deficient practice had a potential to attract flies, insects, and other animals to the dumpster area placing 56 of 59 facility residents at risk for cross-contamination (a transfer of harmful bacteria from one place to another) and had the potential to cause nausea, vomiting and diarrhea. findings: During a concurrent observation and interview on 12/9/2025 at 9:45a.m. with the Dietary Supervisor (DS) of the garbage area located outside the facility near the kitchen, the DS stated two of two dumpsters were not completely closed and covered. The DS stated the trash had not been picked up from Monday 12/8/2025 was still there. The DS stated the trash lids should be closed and indicated if the trash lid is no closed, bugs can come in and bags can break creating an unsanitary environment. During a review of Food Code 2017, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. During a review of the facility's Policy and Procedure (P&P), titled Garbage and Trash, undated, the P&P indicated all food waste must be placed in sealed containers (i.e., plastic bag).		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to provide documented COVID-19 (contagious disease) 2025 to 2026 vaccination (medications used to prevent diseases usually given by injection or by mouth) status, evidence of provision of education on benefits and potential side effects for all employees, including physicians. This failure had the potential to result in staff and residents contracting COVID-19 which could cause serious illness, hospitalization, and death. Findings: During a concurrent interview and record review on 12/10/2025 at 8:10 a.m., with the Infection Prevention Nurse (IPN), the facility's Covid Staff Vaccination Status, undated, was reviewed. The IPN stated there was no documented evidence for all staff of education on benefits and side effects was provided and the offering of 2025 to 2026 Covid-19 booster vaccine. The IPN stated the roster did not include physicians and it should include everyone that has direct access to the residents. During an interview on 12/12/2025 at 7:55 a.m. with the Director of Nursing (DON), the DON stated all staff need to be educated and offered the current COVID-19 booster. During a review of the facility's policy and procedure (P&P) titled, Covid-19 Vaccine Immunization for Residents and HCP, revised 9/2025, the P&P indicated the following:a. The policy is to provide guidance to the facility in meeting the immunization requirements for educating and administering COVID-19 Vaccine and boosters to healthcare personnel (HCP).b. HCP were provided with education regarding the benefits of COVID vaccination and booster potential side effects and adverse events associated with COVID-19 Vaccine and booster.c. The facility keeps a line listing of resident and HCP COVID-19 vaccination status.d. HCP includes physicians.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform the physician when a dialysis treatment was missed for one of two sampled residents (Resident 39). This failure had the potential to result in a delay of treatment, fluid overload and possible deterioration of the resident. Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection), osteomyelitis (inflammation of bone or bone marrow, usually due to infection), end stage renal disease (ESRD-irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 39's History and Physical (H&P), dated 11/19/2025, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 39 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper and lower body dressing, required maximal assistance (helper does more than half the effort) for toileting hygiene, and was dependent for bathing. During an interview on 12/10/2025 at 12:20 p.m. with Resident 39, Resident 39 stated they missed a dialysis session one time. During a concurrent interview and record review on 12/11/2025 at 11:19 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 39's medical record was reviewed. RNS 1 stated Resident 39 had orders for scheduled dialysis every Tuesday, Thursday, and Saturday at 8:00 a.m. RNS 1 stated there was no documentation indicating that Resident 39 received their scheduled dialysis on Tuesday 11/25/2025, and it was possible Resident 39 missed dialysis. RNS 1 stated there was no documentation indicating that the physician was notified that Resident 39 missed dialysis. RNS 1 stated the missed dialysis should have been communicated to the physician so that Resident 39 could have been determined if the resident required an additional dialysis session or evaluation. RNS 1 stated a missed dialysis puts Resident 39 at a risk for fluid overload. During an interview on 12/12/2025 at 11:20 a.m. with the Director of Nursing (DON), the DON stated it is important that the physician is notified of a missed dialysis session so that the physician can intervene and determine the next step. The DON stated if the physician is not notified, there is a risk of a delay of treatment or possible deterioration. During a review of the facility's policy and procedure (P&P), titled Change in a Resident's Condition or Status, revised February 2025, the P&P indicated the facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. During a review of the facility's policy and procedure (P&P), titled Physician Orders and Physician Notification, undated, the P&P indicated the facility ensures that all resident care is provided in accordance with timely, complete, and authenticated physician orders, and that physicians are promptly notified of significant changes in a resident's condition. The P&P indicated all orders and notifications shall be documented accurately to ensure continuity of care and regulatory compliance.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 63) received the Notice of Medicare Non-Coverage (NOMNC- a written notice that informs the resident of their last date of covered services and their right to appeal the decision) at least 48 hours prior to the last covered date. This failure had the potential for the resident to not receive the skilled treatment they may need and violate the residents' right to appeal the decision. Findings: During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including wedge compression fracture (when the front part of the bones of the spine body creating a wedge shape) of lumbar vertebra (lower back bones) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 63's History and Physical (H&P), dated 9/23/2025, the H&P indicated Resident 63 had the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS - a resident assessment tool), dated 9/24/2025, the MDS indicated Resident 63 had no cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and oral hygiene, required supervision for showering, and required moderate assistance (helper does less than half the effort) for toileting and upper and lower body dressing. During a review of Resident 63's Discharge instructions dated 10/14/2025, Resident was discharged home on [DATE]. During a concurrent interview and record review on 12/11/2025 at 2:40 p.m. with the Minimum Data Set Coordinator (MDSC) 1, Resident 63's Notice of Medicare Non-Coverage (NOMNC) dated 10/10/2025 was reviewed. The MDSC 1 stated Resident 39's inpatient skilled nursing services end date was 10/14/2025, and Resident 39 signed that they received the notice on 10/14/2025. MDSC 1 stated the resident should have received the NOMNC at least 48 hours prior to 10/14/2025. During an interview on 12/12/2025 at 11:26 a.m. with the Director of Nursing (DON), the DON stated residents should received the NONMC at least 2 days before discharge of skilled services to be informed of the changes to the care of services and inform the resident of their right to appeal. If the resident does not receive the NOMNC prior to discharge, it would violate the residents' right to appeal the decision, and the resident may not receive the skilled treatment they need. During a review of the facility's policy and procedure (P&P), titled Notice of Admission/Medicare Non-coverage (NAMNC) Policy, undated, the P&P indicated termination of skilled coverage is issued at least 2 days before medicare coverage ends or as soon as the decision is made.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one resident's (Resident 3) Minimum data Set ([MDS] resident assessment tool), dated 11/28/2025, was coded accurately. This deficient practice resulted in an inaccurate assessment of Resident3's current health status and Resident 3's MDS erroneously indicated that Resident 3 received insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) because Resident 3 did not receive any insulin. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was admitted to the facility on [DATE] with diagnosis including Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 3's Minimum Data Set ([MDS] resident assessment tool), dated 11/28/2025, the MDS indicated Resident 3 had severe cognitive impairment. The MDS indicated Resident 3 received insulin injections for three days during the last 7 days or since admission. During a review of Resident 3's Medication Administration Record (MAR) for 11/2025, the MAR did not indicate Resident 3 received insulin injections. During a review of Resident 3's Physician Orders dated 11/2025, the physician orders did not indicate Resident 3 received orders for insulin administration. During a concurrent interview and record review on 12/11/2025 at 11:58 a.m. with the Minimum Data Set Coordinator (MDSC)1, Resident 3's medical records were reviewed. The MDSC 1 stated Resident 3 did not have any orders for insulin, or receive insulin injections. The MDSC 1 stated Resident 3's MDS was inaccurately coded that the resident received insulin injections and should be amended because it was important to have an accurate picture of resident status. During an interview on 12/12/2025 at 7:55 a.m. with the Director of Nursing (DON), the DON stated assessments should be accurate and reflect the residents' plan of care and orders. During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, undated, the P&P indicated any person completing a portion of the MDS must attest to the accuracy of the assessments. During a review of Resident Assessment Instrument (RAI - a standardized evaluation that helps healthcare providers assess a resident's needs, strengths, and preferences) manual, Chapter 1, dated October 2019, the RAI indicated the assessment accurately reflects the resident's status.		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five employees (Licensed Vocational nurse-LVN 3) had an active basic life support certification ([BLS] essential emergency care for cardiac/breathing arrest) . This failure had the potential to result in providing ineffective cardiopulmonary resuscitation (CPR-emergency life-saving procedure that is performed when the heart stops beating) to a resident who is in cardiac arrest. Findings: During a concurrent interview and record review on [DATE] at 2:54 p.m. with the Director of Staff Development (DSD), LVN 3's employee file was reviewed. The DSD stated LVN 3 does not have an active BLS certification on file. During an interview on [DATE] at 11:29 a.m. with the Director of Nursing (DON), the DON stated all nursing staff including Certified Nurse Assistants (CNA)s, LVNs, and Registered Nurses (RNs) are required to have active, not expired, BLS certifications to ensure their skills are up to date with current standards. The DON stated, if nursing staff does not have active BLS certifications, there is a risk that they will provide ineffective cardiopulmonary resuscitation (CPR-emergency life-saving procedure that is performed when the heart stops beating). The DON stated BLS certifications should be maintained in the employee's file. During a review of the facility's policy and procedure (P&P), titled Emergency Procedure - Cardiopulmonary Resuscitation, revised [DATE], the P&P indicated personnel have completed training on the initiation of cardiopulmonary resuscitation (CPR) and basic life support), including defibrillation, for victims of sudden cardiac arrest. The P&P indicated the facility is to obtain and/or maintain America Red Cross or American Heart Association certification in basic Life Support (BLS)/Cardiopulmonary Resuscitation (CPR) for key clinical staff members who will direct resuscitative efforts, including non-licensed personnel.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 39) received dialysis as ordered. This failure had the potential to result in a possible deterioration, fluid overload or even death. Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection), osteomyelitis (inflammation of bone or bone marrow, usually due to infection), end stage renal disease (ESRD-irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 39's History and Physical (H&P), dated 11/19/2025, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 39 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper and lower body dressing, required maximal assistance (helper does more than half the effort) for toileting hygiene, and was dependent for bathing. During an interview on 12/10/2025 at 12:20 p.m. with Resident 39, Resident 39 stated they missed a dialysis session one time. During a concurrent interview and record review on 12/11/2025 at 11:19 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 39's medical record was reviewed. RNS 1 stated Resident 39 had orders for scheduled dialysis every Tuesday, Thursday, and Saturday at 8:00 a.m. RNS 1 stated there was no documentation indicating that Resident 39 received their scheduled dialysis on Tuesday 11/25/2025, and it was possible Resident 39 missed dialysis. RNS 1 stated a missed dialysis puts Resident 39 at a risk for fluid overload. During an interview on 12/12/2025 at 11:20 a.m. with the Director of Nursing (DON), the DON stated it is important that for a resident who is dependent on dialysis, to receive dialysis as scheduled because it is the only way for the resident to expel the toxins in their body. The DON stated if the resident missed a session of dialysis, it places the resident at risk for a health deterioration or death. During a review of the facility's policy and procedure (P&P), titled Physician Orders and Physician Notification, undated, the P&P indicated the facility ensures that all resident care is provided in accordance with timely, complete, and authenticated physician orders, and that physicians are promptly notified of significant changes in a resident's condition. All orders and notifications shall be documented accurately to ensure continuity of care and regulatory compliance.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure two of five employees (Certified Nurse Assistant [CNA] 2 and Restorative Nurse Assistant (RNA) 1) received a performance evaluation annually. This failure had the potential to result in employees not being at current skill level of care which could result in poor health outcomes. Findings: During a concurrent interview and record review on 12/11/2025 at 2:58 p.m. with the Director of Staff Development (DSD), CNA 2 and RNA 1's employee files were reviewed. The DSD stated CNA 2 and RNA 1 did not receive performance evaluations in the last twelve months. The DSD stated performance evaluations should be completed every year and filed in their employee file. The DSD stated if the staff do not receive performance evaluations annually, there is a risk the employee will underperform. During an interview on 12/12/2025 at 11:30 a.m. with the Director of Nursing (DON), the DON stated performance evaluations should be completed once a year or every twelve months. The DON stated if performance evaluations are not completed annually, there is a risk that employees skills are not up to the current standard level of care. During a review of the facility's policy and procedure (P&P), titled Performance Evaluations, revised 12/11/2025, the P&P indicated a performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually thereafter.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the antibiotic stewardship program (effort to measure and improve how antibiotics are prescribed by clinicians) for one of three sampled residents (Resident 39). This deficient practice had the potential to increase antibiotic resistance and provide antibiotics without justification. Findings: During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection), osteomyelitis (inflammation of bone or bone marrow, usually due to infection), end stage renal disease (ESRD-irreversible kidney failure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 39's History and Physical (H&P) dated 11/19/2025, the H&P indicated Resident 39 had the capacity to understand and make decisions. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 11/20/2025, the MDS indicated Resident 39 had moderate cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required setup assistance when eating and for oral hygiene, required moderate assistance (helper does less than half the effort) for upper and lower body dressing, required maximal assistance (helper does more than half the effort) for toileting hygiene, and was dependent for bathing. During a review of Resident 39's Physician Order Summary dated 12/12/2025, the Order Summary indicated an order for Ceftriaxone Sodium Solution (an antibiotic used to treat bacterial infections) 2 grams (GM- a unit of measurement), use 2 GM intravenously (IV-given through the vein) one time a day for right foot infection for 27 days, with a start date of 11/19/2025. During an interview on 12/10/2025 at 12:20 p.m. with Resident 39, Resident 39 stated they are currently receiving antibiotics for the right foot. During a concurrent interview and record review on 12/11/2025 at 1:34p.m. with the Infection Prevention Nurse (IPN), Resident 39's Individual Surveillance Form for Possible Infection and medical record was reviewed. The IPN stated the purpose of the surveillance form was to determine if the antibiotic meets the criteria and to prevent the growth of antibiotic resistant organisms. The IPN stated the screening for McGeer's criteria is determined on the paper form titled Individual Surveillance Form for Possible Infection. The IPN stated if a resident does not meet McGeer's criteria, the facility contacts the physician to inform them. The IPN stated the Individual Surveillance Form for Possible Infection for Resident 39 dated 11/18/2025 was incomplete and did not indicate whether Resident 39's Ceftriaxone sodium solution usage met McGeer's guidelines for a true infection or indicate that the physician was notified. The IPN stated a complete screening is done for all residents on antibiotics. The IPN stated it was unnecessary to inform the physician that the McGeer's criteria was not met if the infection was community acquired and the antibiotic was prescribed by the hospital. The IPN stated if they do not meet criteria, and the physician decides to continue the antibiotics, there should be documentation or a note. During an interview on 12/11/2025 at 11:24 a.m. with the Director of Nursing (DON), the DON stated it is important that all residents on antibiotics are screened using McGeer's criteria on admission for antibiotics stewardship including residents who are prescribed antibiotics from the hospital. The DON stated if McGeer's criteria was not met, the physician should be notified to prevent unnecessary usage of antibiotics. The DON stated if the physician decides to continue the antibiotic, there should be documentation that the physician was notified that a resident did not meet McGeer's criteria. During a review of the facility's policy and procedure (P&P), titled Antibiotic Stewardship Policy, undated, the P&P indicated the facility will implement an antimicrobial stewardship program which will promote appropriate use of antimicrobials. IP will be responsible for infection surveillance and MDRO tracking. IP will collect and review data, such as type of antimicrobial ordered and route of administration, ordering physician, whether appropriate tests such as cultures were obtained prior to antimicrobial being ordered.		