STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555815	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Totally Kids Specialty Healthcare - Sun Valley	10716 LA Tuna Canyon Road Sun Valley, CA 91352

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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. Based on interview and record review, the facilityˆfailed to Inform the resident and/or the responsible party in advance regarding the risks and benefits of administration of a vaccine (a substance that helps the body learn how to fight a specific disease without causing the illness itself) for one of five sampled residents (Resident 3) reviewed during the Infection Control task. This deficient practiceˆresulted inˆResidentˆ3ˆreceiving the COVID-19 (a vaccine designed to induce immunity against SARS-CoV-2ˆ[the virus responsible for coronavirus disease 2019]) vaccineˆwithout Resident 3'sˆresponsibleˆparty knowing the risks and benefits of the vaccine prior to administration.ˆ Findings: During a review of Residentˆ3's admission Record, the admission Record indicated the facility admitted Residentˆ3ˆonˆ7/24/2024ˆwith diagnoses that includedˆcerebralˆpalsy (a group of lifelong disorders affecting body movement, muscle tone, and posture caused by abnormal brain development or damage, usually before birth), tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the windpipeˆ[the main cartilaginous tube in the body that carries air between the voice box and the lungs])ˆstatus and persistent vegetative (a condition where, following severe brain damage, a person is awake but shows no signs of awareness, thought, or purposeful reaction to their environment). During a review of Residentˆ3's Minimum Data Set (MDS- aˆresident assessment tool)ˆdated 12/18/2025, the MDS indicated Residentˆ3's cognition (a mental processˆofˆacquiringˆknowledge and understanding through thought,ˆexperienceˆandˆthe senses) was severely impaired. The MDS indicated Residentˆ3ˆwas dependent on staff withˆoral hygiene,ˆtoileting hygiene,ˆand personal hygiene.ˆ During a review of Resident 3's Immunization History Report,ˆthe Immunization History Reportˆindicatedˆthat Resident 3ˆreceived the COVID-19 vaccine onˆ10/16/2025.ˆ During an interview on 2/22/2026 at 4:09 p.m. with Family Member 1 (FM 1), FM 1ˆstatedˆthat Resident 3 received the COVID-19 vaccineˆwithout FM 1's knowledge. FM 1ˆstatedˆthat FM 1 was informed that Resident 3 received the COVID-19 vaccine only after the vaccine was administered.ˆ During a concurrent interview and record review onˆ2/22/2026ˆatˆ5:14ˆp.m., with theˆDirector of Staff Development (DSD) theˆDSDˆreviewed Residentˆ3'sˆprogress notes from 8/1/2025-10/31/2025. The DSDˆstatedˆthat thereˆwasˆno documented evidence thatˆFM 1ˆwas informedˆin advance, nor was there documentation that informed consent was obtained prior to the administration of the COVID-19 vaccine. The DSD statedˆthatˆit is FM 1's right as Resident 3's responsible party to be informed in advance of the vaccine administration so they may provide informed consent and have the opportunity to ask questions. During aˆreview of the facility's policy and procedureˆ(P&P)ˆtitled, Resident's Rights,ˆwith review date ofˆ12/3/2025, theˆP&Pˆindicatedˆitˆisˆtheˆresident's rightˆtoˆbe fully informed,ˆto be fully informed by the physician of his or her total health status and to be affordedˆthe opportunity to participate on an immediate andˆongoingˆbasis in the total care plan of care including the identification of medical, nursing andˆpsychosocialˆneeds and the planning related services.ˆ ˆ During a review of the facility's P&Pˆtitled, Informed Consent,ˆwith review date of 12/5/2025, the P&Pˆindicatedˆthe facility willˆbe responsible forˆassuring the resident's recordˆcontainsˆdocumentation that the resident has given informed consent prior to the implementation of the proposed treatment procedure.ˆˆ

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive person-centered care plans (a plan for an individual's specific health needs and desired health outcomes) for six of 15 Resident 1, 10, 35, 2, 5, and 3) residents reviewed under care planning by failing to: 1. Develop a care plan addressing Resident 1's critically high (a test result that is so far outside the normal range that itˆindicatesˆa potentiallyˆlife-threatening situation) Depakote (brand nameˆ to valproic acidˆ- medication used to treat epilepticˆseizures [sudden surge of abnormal electrical activity in the brain, causingˆjerking and stiffness]) laboratory value obtained on 10/10/2025. 2. Develop a care plan addressing aˆResident 10`sˆoral care needs.ˆ 3.ˆDevelop a care plan addressing Resident 35's bowel and bladder program. 4. Develop a care plan addressing Resident 2's diagnosis ofˆdiabetes insipidus (a rare disorder causing the body to produce excessive amounts of diluted urine [up to 20 quarts daily] and extreme thirst).ˆ 5. Develop a care plan addressing immunizations (the process of making a person resistant to an infectious disease) for Resident 5, Resident 35, and Resident 3). These deficient practices had the potential toˆresult in failure to deliver the necessary care and servicesˆfor the residents. Findings: 1.During a review of Residentˆ1'sˆAdmissionˆRecord,ˆtheˆadmission Recordˆindicated the facility admitted Residentˆ1ˆonˆ7/17/2024ˆwith diagnoses includingˆspasticˆquadriplegicˆcerebral palsyˆ(the most severe form of cerebral palsyˆ[brain disorder that appears in infancy andˆpermanently affects body movement], caused by brain damage that results in extreme stiffnessˆ[spasticity]), tracheostomyˆ(a surgicalˆprocedure that creates an opening in the neckˆleading directly into the tracheaˆ[windpipe])ˆandˆepilepsyˆˆˆˆ ˆˆ During a review of Residentˆ1's Minimum Data Set (MDS – an assessment and care screening tool) datedˆ1/26/2026,ˆthe MDS indicated the residentˆwas nonverbal andˆrarely/never understood others and rarely/never made themselves understood.ˆThe MDS furtherˆindicatedˆResidentˆ1ˆwas completely dependent (helper does all the effort) on facility staff for all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆˆˆ ˆˆ During a review of Resident 1'sˆlab results report dated 10/10/2025, the report indicated the lab value for Depakote was > (greater than)150 micrograms per milliliter (mcg/ml-unit of measurement). The lab results indicated the therapeutic reference range in the blood stream was 50-100 mcg/ml. The lab result was flagged with red colored HH, indicating the report contained critical results. During a concurrent interview and record review on 2/21/2026 atˆ11:45 a.m. with the Director ofˆStaffˆDevelopmentˆ(DSD), reviewed Resident 1's lab results report dated 10/10/2025, care plans, and progress notes from 10/10/2025 to 2/21/2026. ˆThe DSD stated the lab results report for Depakote indicated a value >150 mcg/ml was flagged in red as HH, indicating a dangerously and critically high level. ˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record reviewˆon 2/21/2026 at 3:15 p.m. with the DSD, the DSD provided an emailˆdated 10/14/2025ˆbetween the Neurology Nurse Practitioner (NP) andˆfacility Case Manager (CM 1) which indicated the NP wroteˆ50-150 mcg/ml was considered within the therapeutic range (the desired beneficial amount in the blood) for Depakote. The DSDˆstatedˆthere was no care plan created to address Resident 1's Depakote lab value of >150 mcg/ml. The DSD further stated that licensed nurses should have created a care plan to address the resident's Depakote level being out of therapeutic range to ensure licensed nurses were informed of the resident's change in condition. During a review of the facility providedˆPolicy and Procedure (P&P)ˆtitled, Resident Care Planning last reviewed on 12/3/2025, the P&Pˆindicated that A comprehensive plan of care will be developed to meet each resident`s medical,ˆdevelopmentalˆand psychosocial needs. This care plan will include the problems/needsˆidentifiedˆin the Resident Assessment Instrument as well as other problems/needs asˆidentifiedˆby the staff,.ˆ 2. During a review of Residentˆ10's admission Record, theˆadmission Recordˆindicated that theˆfacilityˆadmitted the resident onˆ3/07/2024, with diagnoses includingˆencephalopathyˆ(a disturbance of brain function)ˆand encounter for attention to gastrostomy (aˆG tube to provide nutrition or medication because the patient can't swallow liquids or food normally).ˆˆ During a review of Residentˆ10's Minimum Data Set (MDS - a resident assessment tool) datedˆ12/15/2025, the MDS indicated that theˆresident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making wasˆseverelyˆimpaired.ˆThe MDS indicated that Residentˆ10ˆwasˆtotally dependentˆon staff for self-care.ˆˆ  During a review of Resident 10`s care planˆtitled, Activities of Daily Living (ADL-activities such as bathing, dressing and toileting a person performs daily),ˆself-care performance deficit related to debilityˆ(general weakness or reduced strength in the body) post traumatic brain injury (disruption in the normal function of the brain that can be cause by a bump, blow, or jolt to the head),ˆinitiated on 3/24/2025, the CPˆdid not include interventions to address Resident 10's oral care needs.ˆ During a concurrent interview and record onˆ02/21/2026 11:59ˆa.m., with Registered Nurse 2 (RN 2), reviewed Residentˆ10`s CPˆfor ADLs.ˆRN 2ˆstatedˆthat the CP forˆADLs did not include interventions for oral care. RN 2ˆstatedˆthatˆthe CP for ADLs should be resident-centered and specificˆand should have included interventions addressing oral care to prevent the resident from developing oral infections and tooth decay. During a review of the facility`s policy and procedure (PP) titledˆResident Care Planning, last reviewed on 12/3/2025, the PPˆindicatedˆthatˆA comprehensive plan of care will be developed to meet each resident`s medical,ˆdevelopmentalˆand psychosocial needs. This care plan will include the problems/needsˆidentifiedˆin theˆResident Assessment Instrument as well as other problems/needs asˆidentifiedˆby the staff,.ˆ 3. Duringˆa review of Resident 35's admission Record, the admission Record indicated the facility admitted the resident to the facility on [DATE] with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing).ˆ During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touchingˆassistanceˆwith eating, oral hygiene, toileting hygiene, and independent with personal hygiene.ˆThe MDS indicated Resident 35ˆis currently on a toileting program (an individualized, resident-centered plan designed to manage, decrease, or prevent urinary or bowel incontinence). During a concurrent interview and record review onˆ2/21/2026ˆat 5:19ˆp.m. with theˆDirector of Staff Development (DSD),ˆtheˆDSDˆstatedˆthat Resident 35 is participating in a bowel and bladder training program.ˆThe DSDˆreviewed Residentˆ35's care plans andˆstatedˆthat there was no care plan created addressing Resident 35's bowel and bladder training program. TheˆDSDˆstated that Residentˆ35, who has a developmental delay should have a specific care plan for bowel and bladder trainingˆto encourage the resident to participate in his activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), to prevent further decline in functional abilities. During a review of the facility's policy and procedure (P&P) titled Bowel & Bladder Evaluation-Incontinence,ˆreview date 12/5/2025, the P&Pˆindicatedˆanˆindividual care plan will be developed for each resident selected for training. This will be included in the resident long-term care plan.ˆ 4. Duringˆa review of Resident 2's admission Record, the admission Record indicated the facilityˆoriginally admitted Resident 2 on 6/8/2022 andˆreadmitted Resident 2 onˆ9/17/2025ˆwith diagnoses that includedˆdiabetes insipidus (a rare disorder causing the body to produce excessive amounts of diluted urine [up to 20 quarts daily] and extreme thirst).ˆˆ During a review of Resident 2's MDSˆdatedˆ12/27/2025, the MDS indicated Resident 2's cognitive skills (cognition refers to conscious mental activities, and includes thinking, reasoning, understanding, learning, and remembering) for daily decision making were severely impaired. The MDS indicated that Resident 2ˆwas dependent on staff withˆoral hygiene, toileting hygiene, and personal hygiene.ˆThe MDSˆindicated diabetes insipidus was one of Resident 2's active diagnoses. During a concurrent interview and record review onˆ2/21/2026ˆatˆ2:26ˆp.m. with theˆDirector of Staff Developmentˆ(DSD), theˆDSDˆreviewed Resident 2's care plans andˆstatedˆthat there was no care plan created addressingˆResident 2's diagnosis of diabetes insipidus. TheˆDSDˆstatedˆthat Resident 2 should have a specific care plan for Resident 2'sˆdiagnosis of diabetes insipidusˆto guide each discipline in providing appropriate care to the resident. The DSD furtherˆstatedˆthat allˆdepartmentsˆare responsible forˆinitiatingˆand contributing to the development of the resident's care plans.ˆ 5. a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted Resident 5 on 3/17/2022 with diagnoses that includedˆosteochondrodysplasicˆ(a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder).ˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 5's cognition (a mental processˆofˆacquiringˆknowledge and understanding through thought,ˆexperienceˆand senses) wasˆseverely impaired. The MDS indicated Resident 5 required setup or clean-upˆassistanceˆwith eating and substantial/maximalˆ(helper does more than half the effort) assistanceˆwith oral hygiene, toileting hygiene, andˆrequiredˆpartial/moderateˆ(helper does less than half the effort) assistanceˆwith personal hygiene.ˆ During a review of Residentˆ5's Immunization History Record, the Immunization History Recordˆindicatedˆthat Residentˆ5ˆwasˆadministeredˆthe influenza (contagious respiratory infection) vaccine (shots, liquids, pills, or nasal sprays that you take to teach your body's immune system to recognize and defend against harmful germs) and coronavirus disease (COVID-19, an infectious disease caused by the SRAS-CoV-2 virus) vaccine onˆ10/16/2025.ˆ ˆ During a concurrent interview and record review on 2/22/2026 at 5:21 p.m. with the Director of Staff Development (DSD), the DSD reviewedˆResident 5'sˆImmunization History Recordˆandˆstatedˆthat Resident 5 was administered the Influenza Vaccine and COVID-19 vaccine on 10/16/2025. The DSD reviewed Resident 5'sˆcare plans andˆstatedˆthatˆResident 5 did not have a care plan specificˆto the administration of the influenza and COVID-19 vaccines. b. Duringˆa review of Resident 35's admission Record, the admission Record indicated the facility admitted the resident on 10/28/2010 with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing).ˆ During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touchingˆassistanceˆwith eating, oral hygiene, toileting hygiene, and independent with personal hygiene. During a review of Resident 35's Immunization History Record, the Immunization History Recordˆindicatedˆthat Residentˆ35 was administered the influenza vaccine and COVID-19 vaccine on 10/16/2025.ˆ ˆ During a concurrent interview and record review on 2/22/2026 at 5:24ˆp.m. with theˆDSD, the DSD reviewed Residentˆ35's Immunization History Record andˆstatedˆthat Residentˆ35 was administered the influenza vaccine and COVID-19 vaccine on 10/16/2025. The DSD reviewed Residentˆ35's care plans andˆstatedˆthat Residentˆ35 did not have a care plan specific to the administration of the influenza and COVID-19 vaccines. c. Duringˆa review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 7/24/2024ˆwith diagnoses thatˆincluded cerebral palsy (a group of lifelong disorders affecting body movement, muscle tone, and posture caused by abnormal brain development (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or damage, usually before birth), tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the windpipe [the main cartilaginous tube in the body that carries air between the voice box and the lungs]) status, persistent vegetative (a condition where, following severe brain damage, a person is awake but shows no signs of awareness, thought, or purposeful reaction to their environment), dependence on respirator (ventilator- a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own) status.^^^ ^ During a review of Resident 3's Minimum Data Set (MDS- a^resident assessment tool)^dated 12/18/2025, the MDS indicated Resident 3's cognition (a mental process^of^acquiring^knowledge and understanding through thought,^experience^and^the senses) was severely impaired. The MDS indicated Resident 3 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene.^ ^ During a review of Resident^3's Immunization History Record, the Immunization History Record^indicated^that Resident^3^was administered the influenza vaccine and COVID-19 vaccine on 10/16/2025.^ ^ During a concurrent interview and record review on 2/22/2026 at 5:27^p.m. with the DSD, the DSD reviewed Resident^3's Immunization History Record and^stated^that Resident^3^was administered the influenza vaccine and COVID-19 vaccine on 10/16/2025. The DSD reviewed Resident^3's care plans and^stated^that Resident^3^did not have a care plan specific to the administration of the influenza and COVID-19 vaccines.^The DSD continued to^state^that^it important for care plans^to be developed specifically addressing the administration of the influenza and COVID-19 vaccines because it guides the nursing staff on how to appropriately care for the residents who were administered vaccines.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment thatˆwasˆfree from accidents andˆhazardsˆto three of three residents (Resident 1, 18, and 5) reviewed under the accidents care area byˆfailing to: a. and b. Provideˆbilateralˆbed rail padding for Resident 1 and Resident 18, who have a history of seizures (a suddenˆsurge of abnormal electrical activity in the brain, leading to a range of symptoms like muscle spasms, loss of consciousness). c. Implement the facility's policy onˆresident safetyˆand care plans addressing use of a helmet when Resident 5ˆwasˆobservedˆwearing aˆsoft helmetˆwithout a chin strap.Findings: a.ˆDuring a review of Residentˆ1'sˆAdmissionˆRecord,ˆtheˆadmission Recordˆindicated the facility admitted Residentˆ1ˆonˆ7/17/2024ˆwith diagnoses includingˆspasticˆquadriplegicˆcerebral palsyˆ(the most severe form of cerebral palsyˆ[brain disorder that appears in infancy and permanently affects body movement], caused by brain damage that results in extreme stiffnessˆ[spasticity]), tracheostomyˆ(a surgicalˆprocedure that creates an opening in the neckˆleading directly into the tracheaˆ[windpipe])ˆandˆepilepsyˆ(a chronic brain disorder characterized by a tendency to have recurrent, unprovoked seizures).ˆ ˆ During a review of Residentˆ1's Minimum Data Set (MDS – an assessment and care screening tool) datedˆ1/26/2026,ˆthe MDS indicated the residentˆwas nonverbal andˆrarely/never understood others and rarely/never made themselves understood.ˆThe MDS furtherˆindicatedˆResidentˆ1ˆwas completely dependent (helper does all the effort) on facility staff for all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆˆ ˆ During a review of Resident 1'sˆcare plan (CP) addressing risk for injury related to seizures,ˆinitiatedˆonˆ12/19/2024, the CP indicated an interventionˆtoˆensure the resident's safety at all timesˆand to have padded side rails.ˆˆ ˆ During an observation on 2/19/2026 atˆ8:06ˆp.m. in Residentˆ1's room, Residentˆ1ˆwas lying in bed with his eyes closedˆand attached to a ventilatorˆ(a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own). The bed rails on Resident 1's bed were made of metal, andˆonly theˆleft side bed rail had padding in place. ˆˆˆ During a concurrent observation and interview on 2/19/2026 atˆ8:13ˆp.m. in Residentˆ1's room withˆLicensed Vocationalˆ Nurse (LVNˆ3),ˆLVNˆ3ˆstated Residentˆ1's bed did not have the necessary padding onˆthe rightˆbedrail to keep him safe during a seizure.ˆLVN 1ˆstatedˆthe padding is to protect the resident's head andˆbody from the uncontrolled shakingˆduring aˆseizure.ˆˆ ˆ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/21/2026 atˆ4:45 p.m. with the Director ofˆStaffˆDevelopmentˆ(DSD), the DSDˆstatedˆthe facility staff did not followˆtheir facility policyˆto apply padding toˆboth sides ofˆResidentˆ1's side rails and without the padding, Residentˆ1ˆcould sustain injuriesˆduring aˆseizure.ˆˆ ˆ During a review of the facility providedˆpolicy and procedure (P&P)ˆtitled, Seizureˆ Management last reviewed on 12/3/2025, the P&Pˆindicatedˆall residents with seizure precaution, willˆhave safety side rail padding in place at all timesˆon both right and left sides.ˆˆˆ b.ˆDuring a review of Resident 18's admission Record, the admission Record indicated the facility admitted Resident 18ˆonˆ8/21/2014 with diagnoses includingˆanoxicˆbrain damageˆ(damage cause by lack of oxygen),ˆtracheostomyˆandˆunspecified convulsionsˆ(suddenˆand violent shaking or stiffening of the body's muscles caused by abnormal brain electrical activity)ˆ ˆ During a review of Residentˆ18's MDS dated [DATE],ˆthe MDS indicated the residentˆwas in aˆpersistent vegetative stateˆ(whenˆpatients are awake but have no awareness of themselves orˆofˆtheir surroundings).ˆThe MDS furtherˆindicatedˆResidentˆ1ˆwas completely dependent (helper does all the effort) on facility staff for all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆˆ ˆ During a review of Resident 18'sˆCP on seizure disorder related toˆbrain damage status post (after) drowning,ˆinitiatedˆonˆ8/20/2024, the CP indicated an intervention toˆprotect the resident from injury at all times.ˆˆˆ ˆ During an observation on 2/19/2026 atˆ7:04ˆp.m. in Resident 18's room, Resident 18ˆwas lying in bed withˆherˆeyesˆopenˆand attached to a ventilator.ˆResident18's bedˆhad two upper and two lowerˆmetalˆside rails and onlyˆthe bottom left side rail had padding in place. ˆˆˆ During a concurrent observation and interview on 2/19/2026 atˆ7:08ˆp.m. in Resident 18's room with LVNˆ2, LVNˆ2ˆstatedˆshe was unsure whyˆResident 18's bed only had one of four side rails on because Resident 18 had a history of seizures and convulsions.ˆLVN 2 stated Resident 18 especially needed the upper side rails padded to protect her head from injury.ˆˆ ˆ During an interview on 2/21/2026 at 4:51ˆp.m. with the DSD, the DSDˆstatedˆtheyˆdid not follow the facility's policy to apply paddingˆtoˆResident 18's side rails. The DSDˆstatedˆResident 18 has convulsions andˆwithout the padded side rails Resident 18ˆcould sustain injuries.ˆˆ (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ˆ During a review of the facility's P&Pˆtitled, Seizure Management last reviewed on 12/3/2025, the P&Pˆindicatedˆall residents with seizure precaution, willˆhave safety side rail padding in place at all timesˆon both right and left sides. c. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 3/17/2022 with diagnoses that includedˆosteochondrodysplasiaˆ(a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder).ˆ During a review of Resident 5's MDS dated [DATE], the MDS indicated Resident 5's cognition (a mental processˆofˆacquiringˆknowledge and understanding through thought,ˆexperienceˆand senses) wasˆseverely impaired. The MDS indicated Resident 5 required setup or clean-upˆassistanceˆwith eating and substantial/maximalˆassistanceˆ(helper provides more than half of the effort) with oral hygiene, toileting hygiene, andˆrequiredˆpartial/moderateˆassistanceˆwith personal hygiene.ˆThe MDSˆindicatedˆthat Resident 5 has had a fall since admission/entry or reentry or prior to assessment.ˆ During a review of Resident 5'sˆorderˆsummaryˆreport, theˆorder summary reportˆindicatedˆan order dated 1/9/2025, for Resident 5 to wear soft helmet intermittently and as tolerated while out on crib to preventˆinjury due to fall risk.ˆˆ During a review of Resident 5's CPˆforˆhigh riskˆfor falls related to unawareˆof safety needs,ˆrevised on 12/29/2025, the CP indicatedˆan intervention for Resident 5 to wear soft helmet intermittently while out of bed as tolerated to preventˆinjury related to fall risk.ˆ During a review of Resident 5 CP forˆuse of a helmet related to fall risk, poor safety awareness,ˆinitiatedˆ1/9/2025,ˆthe CP indicatedˆan intervention to ensure helmet is in good working condition and to discard andˆnotify the Interdisciplinary Team (IDT-a group of healthcare professionals from different disciplines who work together to plan and provide care for a resident)ˆif new helmet isˆrequired.ˆˆ During anˆobservation onˆ2/20/2026ˆatˆ7:56ˆp.m. in Resident 5's room,ˆobservedˆResident 5 ambulating independently in the room without wearing theˆsoftˆhelmet.ˆˆ During an observation on 2/21/2026 atˆ8:55ˆa.m. in Resident 5's room,ˆobservedˆResident 5ˆout of bed having breakfast, wearing the soft helmet without the chin strap. During an observation on 2/21/2026 atˆ5:05ˆp.m. in Resident 5's room,ˆobservedˆResident 5ˆambulating independently in the room without wearing theˆsoftˆhelmet.ˆˆ During a concurrent observation and interview onˆ2/21/2026 at 5:06 p.m.,ˆwith Certified Nursing Assistant 1 (CNAˆ1)ˆin Resident 5's room,ˆobserved Resident 5 wearing the soft helmet without the chin strap. CNA 1ˆstatedˆthatˆResident 5 is wearing theˆsoftˆhelmet, but the helmet did not have a chin strap. CNA 1 statedˆthatˆthere was no chin strap because the resident chews on the chin strap. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	CNA 1ˆstatedˆthat the Rehabilitation Department had been requested multiple timesˆto provide a replacement soft helmet; however, a replacement had not been provided. ˆCNA 1 further statedˆthat Resident 5 needs to wear aˆsoftˆhelmetˆforˆfall prevention and safety because the resident runs around frequently. During a concurrent observation and interview on 2/21/2026 at 5:37ˆp.m., withˆthe Director of Staff Development (DSD)ˆin Resident 5's room,ˆthe DSDˆobservedˆResident 5.ˆThe DSDˆstatedˆthat Resident 5 is wearing hisˆsoftˆhelmet but there is no chin strapˆon theˆsoftˆhelmet.ˆThe DSDˆstatedˆthat Resident 5ˆhas toˆwearˆaˆsoftˆhelmet with the chin strap to help prevent injuries.ˆThe DSD continued toˆstateˆthatˆall direct care staffˆare responsibleˆforˆmaking sure Resident 5'sˆsoftˆhelmet is in good condition.ˆ During an interviewˆon 2/21/2026 at 5:57 p.m. withˆthe DSD, the DSDˆstatedˆthat Resident 5'sˆsoftˆhelmet did not have a chin strap,ˆwhich madeˆResident 5'sˆsoftˆhelmet ineffective in preventing injury. The DSD furtherˆstatedˆthatˆdirect care staff should have noticed theˆmissing chin strap and requested a replacement soft helmet from the registered nurses to help prevent injuries. During aˆreview of the facility's policies and proceduresˆ(P&P)ˆtitled Residentˆ Safety,ˆreviewed12/5/2025,ˆthe P&Pˆindicatedˆallˆthat employees will use safe techniques and procedures while treating residents toˆassure resident safety at all times .ˆensure safety devices are in place as ordered. Safety devices may include,ˆbut are not limitedˆto:ˆsoft helmet,ˆhard helmet,ˆsafetyˆpadsˆand landing pads

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure physician's orders were obtain prior to the administration of the COVID-19 vaccine (a vaccine designed to induce immunity against SARS-CoV-2 [the virus responsible for coronavirus disease 2019]) for three of five sampled residents (Resident 5, Resident 35, and Resident 3). This deficient practice placed Resident 5, Resident 35, and Resident 3 at risk for experiencing adverse effects and for having contraindications or allergies that were assessed by a physician. Findings: a. Duringˆa review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident to the facility on 3/17/2022 with diagnoses that includedˆosteochondrodysplasiaˆ(a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder).ˆ During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 5's cognition (a mental processˆofˆacquiringˆknowledge and understanding through thought,ˆexperienceˆand senses) wasˆseverely impaired. The MDS indicated Resident 5 required setup or clean-upˆassistanceˆwith eating and substantial/maximalˆ(helper does more than half the effort) assistanceˆwith oral toileting hygiene andˆrequiredˆpartial/moderateˆ(helper does less than half the effort) assistanceˆwith personal hygiene.ˆ During a review of Residentˆ5's Immunization History Record, the Immunization History Recordˆindicatedˆthat Residentˆ5ˆwasˆadministeredˆthe coronavirus disease (COVID-19, an infectious disease caused by the SRAS-CoV-2 virus) vaccine onˆ10/16/2025.ˆ During a concurrent interview and record review on 2/22/2026 at 5:21 p.m. with the Director of Staff Development (DSD), the DSD reviewed Resident 5's Immunization History Record and physician orders. The DSD stated that Resident 5 was administered the COVID-19 vaccine on 10/16/2025, however; there was no physician's order for the administration of the vaccine. During a concurrent interview and record review on 2/23/2026 atˆ9:27ˆa.m. with theˆMedical Records Directorˆ(MRD),ˆthe MRD reviewed Resident 5's active and discontinued physician's orders andˆstatedˆthat there was no physician's orderˆtoˆadminister theˆCOVID-19 vaccine to Resident 5. b. Duringˆa review of Resident 35's admission Record, the admission Record indicated the facility admitted the resident to the facility on [DATE] with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing).ˆ During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touchingˆassistanceˆwith eating, oral hygiene, toileting hygiene, and independent with personal hygiene.ˆ During a review of Resident 35's Immunization History Record, the Immunization History Recordˆindicatedˆthat Resident 35 was administered the COVID-19 vaccine on 10/16/2025.ˆ During a concurrent interview and record review on 2/22/2026 at 5:24 p.m. with the Director of Staff Development (DSD), the DSD reviewed Resident 35's Immunization History Record and physician orders. The DSD stated that Resident 35 was administered the COVID-19 vaccine on 10/16/2025, however; there was no physician's order for the administration of the vaccine. During a concurrent interview and record review on 2/23/2026 atˆ9:32ˆa.m. with theˆMedical Records Directorˆ(MRD),ˆthe MRD reviewed Resident 35's active and discontinued physician's orders andˆstatedˆthat there was no physician's orderˆtoˆadminister theˆCOVID-19 vaccine to Resident 35. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. Duringˆa review of Resident 3's admission Record, the admission Record indicated the facility admitted Resident 3 on 7/24/2024 withˆdiagnosesˆthat included cerebralˆpalsy (a group of lifelong disorders affecting body movement, muscle tone, and posture caused by abnormal brain development or damage, usually before birth), tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the windpipe [the main cartilaginous tube in the body that carries air between the voice box and the lungs]) status, persistent vegetative (a condition where, following severe brain damage, a person is awake but shows no signs of awareness, thought, or purposeful reaction to their environment), dependence on respirator (ventilator- a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own) status.ˆˆˆ During a review of Resident 3's Minimum Data Set (MDS- aˆresident assessment tool)ˆdated 12/18/2025, the MDS indicated Resident 3's cognition (a mental processˆofˆacquiringˆknowledge and understanding through thought,ˆexperienceˆandˆthe senses) was severely impaired. The MDS indicated Resident 3 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene.ˆ ˆ During a review of Residentˆ3's Immunization History Record, the Immunization History Recordˆindicatedˆthat Residentˆ3ˆwas administered the influenza vaccine and COVID-19 vaccine on 10/16/2025.ˆ ˆ During a concurrent interview and record review on 2/22/2026 at 5:27 p.m. with the Director of Staff Development (DSD), the DSD reviewed Resident 3's Immunization History Record and physician orders. The DSD stated that Resident 3 was administered the COVID-19 vaccine on 10/16/2025, however; there was no physician's order for the administration of the vaccine. During an interview on 2/23/2026 at 8:13 a.m. with the Infection Preventionist (IP), the IPˆstatedˆthat a COVID-19 clinic comes to the facility and the clinic's pharmacist administers the COVID-19 vaccine to the residents and that licensed nurses do not administer the COVID-19 vaccine to the residents in the facility. The IPˆstatedˆthat she was not aware that there were no orders to administer COVID-19 vaccine to Resident 5, Resident 35, and Resident 3. The IPˆstatedˆthat she did not obtain physician orders for the COVID-19 vaccine prior to the administration of the COVID-19 vaccine by the clinic pharmacist. During a follow up interview on 2/23/2026 at 8:45 a.m. with the IP, the IPˆstatedˆthat it is important to obtain a physician's orders for the administration of anyˆvaccineˆto ensure resident safety. During a concurrent interview and record review on 2/23/2026 atˆ9:45ˆa.m. with theˆMRD,ˆthe MRD reviewed Resident 3's active and discontinued physician's orders andˆstatedˆthat there was no order to administer the COVID-19 vaccine to Resident 3. During a review of the facility's policy and procedure (P&P) titled Medication Administration, review date 12/5/2025, the P&P indicated that physician ordered medication to be administered by licensed medical/nursing personnel using the six rights of medication administration:ˆThe rightˆresident,ˆdose,ˆamount,ˆtime,ˆroute,ˆand rationale.ˆAll medication to be administered following the proper guidelines and techniques: a.ˆCheck order on medication record with label on prescribed medication for proper resident name,ˆmedication,ˆdosage,ˆtime,ˆroute,ˆand rationale.ˆ

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors by failing to ensure a resident was given clonidine (medication used to treat hypertension [high blood pressure - when the force of the blood pushing on the blood vessel walls is too high]) for its indication of use as ordered for one of five sampled residents (Resident 1). This deficient practice had the potential to cause adverse side effects and cause confusion in the delivery of care and services for the resident.Findings: During a review of Residentˆ1'sˆAdmissionˆRecord,ˆtheˆadmission Recordˆindicated the facility admitted Residentˆ1ˆonˆ7/17/2024ˆwith diagnoses includingˆspasticˆquadriplegicˆcerebral palsyˆ(the most severe form of cerebral palsyˆ[brain disorder that appears in infancy andˆpermanently affects body movement], caused by brain damage that results in extreme stiffnessˆ[spasticity]), tracheostomyˆ(a surgicalˆprocedure that creates an opening in the neckˆleading directly into the tracheaˆ[windpipe]),ˆandˆepilepsy (a disorder in which nerve cell activity in the brain is disturbed, causing seizures [sudden, uncontrolled body movements and changes in behavior that occur because of abnormal electrical activity in the brain]). ˆˆ During a review of Residentˆ1's Minimum Data Set (MDS - a resident assessment tool) datedˆ1/26/2026,ˆthe MDS indicated the residentˆwas nonverbal andˆrarely/never understood others and rarely/never made themselves understood.ˆThe MDS furtherˆindicatedˆ Residentˆ1ˆwas completely dependent (helper does all the effort) on facility staff for all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆˆˆ During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the following orders: - Clonidine oral tablet 0.1 milligram (mg- unit of measurement), give 0.5 tablet via G-Tube (gastrostomy tube - a medical device inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medication) every 12 hours as needed for tachycardia (increased heart rate) >160 beats per minute (bpm) or hypertension (elevated blood pressure) systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) >150 millimeters of mercuryˆ (mmHg- unit of measurement), ordered 4/24/2026. During a review of Resident 1's Electronic Medication Administration Record (EMAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/2026, the EMAR indicated clonidine oral tablet 0.1 mg as needed for tachycardia >160 bpm or hypertension SBP >150 mmHg was given but there was no documentation to indicate why clonidine was given to Resident 1 and how high the SBP and heart rate was. Resident 1's EMAR indicated the following:- On 2/2/2026 at 1:59 a.m., clonidine was given, but there is no indication why it was given. - On 2/7/2026 at 4:50 p.m., clonidine was given, but there is no indication why it was given. - On 2/9/2026 at 7:30 p.m., clonidine was given, but there is no indication why it was given. - On 2/11/2026 at 3:59 a.m., clonidine was given, but there is no indication why it was given. - On 2/12/2026 at 7:20 p.m., clonidine was given, but there is no indication why it was given. - On 2/13/2026 at 8:29 a.m., clonidine was given, but there is no indication why it was given. - On 2/15/2026 at 7:31 a.m., clonidine was given, but there is no indication why it was given. - On 2/16/2026 at 8:00 p.m., clonidine was given, but there is no indication why it was given. - On 2/20/2026 at 5:29 a.m., clonidine was given, but there is no indication why it was given. During a concurrent interview and record review on 2/21/2026 at 10:55 a.m., with the Director of Staff Development (DSD), reviewed Resident 1's EMAR dated 2/2026 and Progress Notes dated 2/2026. The DSD stated when Resident 1's clonidine order was transcribed initially, the licensed nurse must have forgotten to add supplemental documentation in order to document the indication/reason why the medicine was given. The DSD stated this could be dangerous, because the oncoming nurse will not know why it was given, nor will there be a quantifiable log for the doctors or pharmacist to review on why the medication was given. During a review of the facility's policy and procedure (P&P) titled, Documentation: Licensed Nursing Staff (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(LNS), last reviewed on 12/3/2025, the P&P indicated the vital signs must be recorded each shift by LNS (Registered Nurses or Licensed Vocational Nurses - not CNAs) and documented in PCC (computer documenting system). The policy further indicates for PRN (as needed) medications or treatments must include: .reason for administration and vitals.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's immunization policy by failing to ensure residents' responsible parties were provided education regarding the influenza vaccine (prevents infection from influenza [a common, sometimes deadly viral infection of the nose, throat, and lungs]) for three of five sampled residents (Resident 5, Resident 35, Resident 3). This deficient practice had the potential for Resident 5, Resident 35, and Resident 3's responsible party to not be aware of the risks and benefits of the influenza vaccine. Findings: a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 3/17/2022 with diagnoses that included osteochondrodysplasia (a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder). During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 5's cognition (a mental process of acquiring knowledge and understanding through thought, experience and senses) was severely impaired. The MDS indicated Resident 5 required setup or clean-up assistance with eating and substantial/maximal assistance with oral hygiene, toileting hygiene, and required partial/moderate assistance with personal hygiene. During a review of Resident 5's Immunization History Record, the Immunization History Record indicated that Resident 5 was administered the influenza vaccine on 10/16/2025. During an interview on 2/22/2026 at 2:41 p.m., with the Infection Preventionist (IP), the IP stated that the IP does inform residents' responsible parties to provide education about the influenza vaccine. The IP stated that it is the responsibility of the medical records department to provide influenza vaccine information. During an interview on 2/22/2026 at 3:21 p.m., with the Medical Records Director (MRD), the MRD stated that the MRD sends influenza vaccine information to residents' responsible parties to provide education about the influenza vaccine. The MRD stated that the influenza vaccine information was sent to all residents' responsible parties through regular mail and there is no mail confirmation that residents' responsible parties received the information. The MRD continued to state that the MRD does not have any documentation that residents' responsible parties received influenza vaccine information. During a concurrent interview and record review on 2/22/2026 at 5:21 p.m., with the Director of Staff Development (DSD), reviewed Resident 5's Immunization History Record. The DSD stated that Resident 5 was administered the influenza vaccine on 10/16/2025. The DSD reviewed Resident 5's nursing progress notes and social services progress notes from 8/2025-10/2025 and stated that there was no documented evidence that Resident 5's responsible party received influenza vaccine information prior to the administration of the influenza vaccine. b. During a review of Resident 35's admission Record, the admission Record indicated the facility admitted the resident on 10/28/2010 with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing). During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touching assistance with eating, oral hygiene, toileting hygiene, and independent with personal hygiene. During a review of Resident 35's Immunization History Record, the Immunization History Record indicated that Resident 35 was administered the influenza vaccine on 10/16/2025. During an interview on 2/22/2026 at 2:41 p.m., with the IP, the IP stated that the IP does inform residents' responsible parties to provide education about the influenza vaccine. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP stated that it is the responsibility of the medical records department to provide influenza vaccine information. During an interview on 2/22/2026 at 3:21 p.m., with the MRD, the MRD stated that the MRD sends influenza vaccine information to residents' responsible parties to provide education about the influenza vaccine. The MRD stated that the influenza vaccine information was sent to all residents' responsible parties through regular mail and there is no mail confirmation that residents' responsible parties received the information. The MRD continued to state that the MRD does not have any documentation that residents' responsible parties received influenza vaccine information. During a concurrent interview and record review on 2/22/2026 at 5:24 p.m., with the DSD, reviewed Resident 35's Immunization History Record. The DSD stated that Resident 35 was administered the influenza vaccine on 10/16/2025. The DSD reviewed Resident 35's nursing progress notes and social services progress notes from 8/2025-10/2025 and stated that there was no documented evidence that Resident 35's responsible party received influenza vaccine information prior to the administration of the influenza vaccine. c. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 7/24/2024 with diagnoses that included cerebral palsy (a group of lifelong disorders affecting body movement, muscle tone, and posture caused by abnormal brain development or damage, usually before birth), tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the windpipe) status, persistent vegetative (a condition where, following severe brain damage, a person is awake but shows no signs of awareness, thought, or purposeful reaction to their environment), dependence on respirator (ventilator- a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own) status. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was severely impaired. The MDS indicated Resident 3 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 3's Immunization History Record, the Immunization History Record indicated that Resident 3 was administered the influenza vaccine on 10/16/2025. During an interview on 2/22/2026 at 2:41 p.m., with the IP, the IP stated that the IP does inform residents' responsible parties to provide education about the influenza vaccine. The IP stated that it is the responsibility of the medical records department to provide influenza vaccine information. During an interview on 2/22/2026 at 3:21 p.m., with the MRD, the MRD stated that the MRD sends influenza vaccine information to residents' responsible parties to provide education about the influenza vaccine. The MRD stated that the influenza vaccine information was sent to all residents' responsible parties through regular mail and there is no mail confirmation that residents' responsible parties received the information. The MRD continued to state that the MRD does not have any documentation that residents' responsible parties received influenza vaccine information. During a concurrent interview and record review on 2/22/2026 at 5:27 p.m., with the DSD, reviewed Resident 3's Immunization History Record. The DSD stated that Resident 3 was administered the influenza vaccine on 10/16/2025. The DSD reviewed Resident 3's nursing progress notes and social services progress notes from 8/2025-10/2025 and stated that there was no documented evidence that Resident 3's responsible party received influenza vaccine information prior to the administration of the influenza vaccine. During an interview on 2/23/2026 at 8:13 a.m., with the IP, the IP stated that it important to provide residents' responsible parties with vaccine information so that the residents' responsible parties will know the risk and benefits of the vaccine and they also have the right to be informed. During a review of the facility's policy and procedure (P&P) titled, Immunization, review date 12/5/2025, the P&P indicated Social Service staff and/or IP to provide parent/legal representative with Vaccine Information Sheet(s) when indicated. Document when the Information Sheet(s) were provided. Vaccine information sheet can be given at anytime prior to the vaccine being administered.

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	555815	A. Building B. Wing	02/23/2026

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement the facility's immunization policy by failing to ensure residents' responsible parties were provided education regarding the Coronavirus Disease vaccine (prevents infection from Coronavirus Disease [COVID-19, a severe respiratory illness caused by virus and transmitted from person to person]) for three of five sampled residents (Resident 5, Resident 35, Resident 3). This deficient practice had the potential for Resident 5, Resident 35, and Resident 3's responsible party to not be aware of the risks and benefits of the COVID-19 vaccine. Findings: a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 3/17/2022 with diagnoses that included osteochondrodysplasia (a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder). During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 5's cognition (a mental process of acquiring knowledge and understanding through thought, experience and senses) was severely impaired. The MDS indicated Resident 5 required setup or clean-up assistance with eating and substantial/maximal assistance with oral hygiene, toileting hygiene, and required partial/moderate assistance with personal hygiene. During a review of Resident 5's Immunization History Record, the Immunization History Record indicated that Resident 5 was administered the COVID-19 vaccine on 10/16/2025. During an interview on 2/22/2026 at 2:41 p.m., with the Infection Preventionist (IP), the IP stated that the IP does inform and provide education to residents' responsible parties about the COVID-19 vaccine. During an interview on 2/22/2026 at 3:21 p.m., with the Medical Records Director (MRD), the MRD stated that the MRD sends COVID-19 vaccine information to residents' responsible parties to provide education about the COVID-19 vaccine. The MRD stated that the COVID-19 vaccine information was sent to all residents' responsible parties through regular mail and there is no mail confirmation that residents' responsible parties received the information. The MRD continued to state that the MRD does not have any documentation that residents' responsible parties received COVID-19 vaccine information. During a concurrent interview and record review on 2/22/2026 at 5:21 p.m., with the Director of Staff Development (DSD), reviewed Resident 5's Immunization History Record. The DSD stated that Resident 5 was administered the COVID-19 vaccine on 10/16/2025. The DSD reviewed Resident 5's nursing progress notes and social services progress notes from 8/2025-10/2025 and stated that there was no documented evidence that Resident 5's responsible party received COVID-19 vaccine information prior to the administration of the COVID-19 vaccine. b. During a review of Resident 35's admission Record, the admission Record indicated the facility admitted the resident on 10/28/2010 with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing). During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touching assistance with eating, oral hygiene, toileting hygiene, and independent with personal hygiene. During a review of Resident 35's Immunization History Record, the Immunization History Record indicated that Resident 35 was administered the COVID-19 vaccine on 10/16/2025. During an interview on 2/22/2026 at 2:41 p.m., with the IP, the IP stated that (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the IP does inform and provide education to residents' responsible parties about the COVID-19 vaccine. During an interview on 2/22/2026 at 3:21 p.m., with the MRD, the MRD stated that the MRD sends COVID-19 vaccine information to residents' responsible parties to provide education about the COVID-19 vaccine. The MRD stated that the COVID-19 vaccine information was sent to all residents' responsible parties through regular mail and there is no mail confirmation that residents' responsible parties received the information. The MRD continued to state that the MRD does not have any documentation that residents' responsible parties received COVID-19 vaccine information. During a concurrent interview and record review on 2/22/2026 at 5:24 p.m., with the DSD, reviewed Resident 35's Immunization History Record. The DSD stated that Resident 35 was administered the COVID-19 vaccine on 10/16/2025. The DSD reviewed Resident 35's nursing progress notes and social services progress notes from 8/2025-10/2025 and stated that there was no documented evidence that Resident 35's responsible party received COVID-19 vaccine information prior to the administration of the COVID-19 vaccine. c. During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 7/24/2024 with diagnoses that included cerebral palsy (a group of lifelong disorders affecting body movement, muscle tone, and posture caused by abnormal brain development or damage, usually before birth), tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the windpipe) status, persistent vegetative (a condition where, following severe brain damage, a person is awake but shows no signs of awareness, thought, or purposeful reaction to their environment), dependence on respirator (ventilator- a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own) status. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was severely impaired. The MDS indicated Resident 3 was dependent on staff with oral hygiene, toileting hygiene, and personal hygiene. During a review of Resident 3's Immunization History Record, the Immunization History Record indicated that Resident 3 was administered the COVID-19 vaccine on 10/16/2025. During an interview on 2/22/2026 at 2:41 p.m., with the IP, the IP stated that the IP does inform and provide education to residents' responsible parties about the COVID-19 vaccine. During an interview on 2/22/2026 at 3:21 p.m., with the MRD, the MRD stated that the MRD sends COVID-19 vaccine information to residents' responsible parties to provide education about the COVID-19 vaccine. The MRD stated that the COVID-19 vaccine information was sent to all residents' responsible parties through regular mail and there is no mail confirmation that residents' responsible parties received the information. The MRD continued to state that the MRD does not have any documentation that residents' responsible parties received COVID-19 vaccine information. During a concurrent interview and record review on 2/22/2026 at 5:27 p.m., with the DSD, reviewed Resident 3's Immunization History Record. The DSD stated that Resident 3 was administered the COVID-19 vaccine on 10/16/2025. The DSD reviewed Resident 3's nursing progress notes and social services progress notes from 8/2025-10/2025 and stated that there was no documented evidence that Resident 3's responsible party received COVID-19 vaccine information prior to the administration of the COVID-19 vaccine. During an interview on 2/23/2026 at 8:13 a.m. with the IP, the IP stated that it important to provide residents' responsible party with vaccine information so that the residents' responsible party will know the risk and benefits of the vaccine and they also have the right to be informed. During a review of the facility's policy and procedure (P&P) titled, Immunization, review date 12/5/2025, the P&P indicated Social Service staff and/or IP to provide parent/legal representative with Vaccine Information Sheet(s) when indicated. Document when the Information Sheet(s) were provided. Vaccine information sheet can be given at anytime prior to the vaccine being administered.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident's dignity and promoted respect by failing to ensure Licensed Vocational Nurse (LVN 1) knocked or request permission before entering the room of one of two sampled residents (Resident 37) reviewed under the dignity care area. This deficient practice violated the resident`s rights to be treated with respect and dignity and had the potential to negatively affect the resident's sense of self-worth and self-esteem. Findings: During a review of Resident 37's admission Record, the admission Record indicated the facility initially admitted Resident 37 on 10/18/2018 and readmitted the resident on 11/7/2023, with diagnoses including tracheostomy (a surgical procedure that creates an opening in the neck leading directly into the trachea [windpipe]) and dependence on a ventilator (a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own). During a review of Resident 37's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 1/12/2026, the MDS indicated the resident usually makes herself understood and usually understood others. The MDS further indicated Resident 37 required supervision (helper provides verbal cues and some touch assistance) with eating, upper body dressing and putting on shoes. The MDS indicated Resident 37 required partial assistance (helper does less than half the effort) with toileting, bathing, lower body dressing and personal hygiene. During an observation and interview on 2/20/26 at 7:57 p.m., in the hallway near the entrance of Resident 37's room with LVN 1, LVN 1 was observed entering Resident 37`s room through a closed door, without knocking on the door or asking permission to go in. Observed Resident 37 standing on the right side of her bed, nearest to the door. Upon leaving the room, LVN 1 was interviewed and stated that she should have knocked and asked permission prior to entering to ensure Resident 37's privacy and dignity. During an interview on 2/22/26 at 5:26 p.m. with the Director of Staff Development, (DSD), the DSD stated that anyone entering a resident`s room must knock and ask permission prior to entering the resident`s room. The DSD stated residents' privacy and dignity should be respected and promoted at all times. During a review of the facility`s policy and procedure (P&P) titled Resident Rights last reviewed on 12/3/2025, the P&P indicated that the facility shall treat each resident with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs. During a review of the facility`s policy and procedure (P&P) titled Privacy last reviewed on 12/3/2025 the P&P indicated that the facility would ensure that each resident's right to privacy will be respected.

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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. Based on interview and record review, the facility failed to notify a resident's responsible party (RP-the person designated for all care decisionsˆof a resident)ˆ regarding a change of condition for one of five residents (Resident 1) reviewed for unnecessary medications when the facility failed to notify Resident 1's responsible party (RP 1) of a critically high (a test result that is so far outside the normal range that itˆindicatesˆa potentiallyˆlife-threatening situation) Depakote (brand nameˆto valproic acidˆ- medication used to treat epilepticˆseizuresˆ [sudden surge of abnormal electrical activity in the brain, causingˆjerking and stiffness])ˆlaboratory value (reference range was 50-100 micrograms per millimeter [mcg/ml-unit of measurement]) greater than 150 mcg/ml on 10/10/2025. This deficient practiceˆresulted inˆRP 1ˆnot being informedˆof the critical lab values andˆprevented RP 1 from participatingˆinˆResident 1'sˆcare planning. Findings:ˆˆ During a review of Residentˆ1'sˆAdmissionˆRecord,ˆtheˆadmission Recordˆindicated the facility admitted Residentˆ1ˆonˆ7/17/2024ˆwith diagnoses includingˆspasticˆquadriplegicˆcerebral palsyˆ(the most severe form of cerebral palsyˆ[brain disorder that appears in infancy and permanently affects body movement], caused by brain damage that results in extreme stiffnessˆ[spasticity]), tracheostomyˆ(a surgicalˆprocedure that creates an opening in the neckˆleading directly into the tracheaˆ[windpipe])ˆandˆepilepsyˆˆˆ ˆ During a review of Residentˆ1's Minimum Data Set (MDS - an assessment and care screening tool) datedˆ1/26/2026,ˆthe MDS indicated the residentˆwas nonverbal andˆrarely/never understood others and rarely/never made themselves understood.ˆThe MDS furtherˆindicatedˆResidentˆ1ˆwas completely dependent (helper does all the effort) on facility staff for all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆˆ During a review of Resident 1'sˆlab results report dated 10/10/2025, the report indicated the lab value for Depakote was > (greater than)150 mcg/ml. The lab results indicated the therapeutic reference range in the blood stream was 50-100 mcg/ml. The lab result was flagged with red colored HH, indicating the report contained critical results. During a review of Resident 1's facility provided audit of the resident's Change of Condition (COC - a record that tracks any new, worsening, or unexpected change in a patient's physical, mental, or functional status) documents, there was no documented COC assessment completed following the lab result of Depakote obtained on 10/10/2025. During a review of Resident 1's progress notes from 10/10/25 to 2/21/2026, there was no documented evidence that RP 1 was notified of Resident 1's critical Depakote lab value results on 10/10/2025. During an attempted telephone interview on 2/21/2026 at 12:33 p.m. with RP 1, the call was not answered and a message was left. An attempt to call RP 1 again on 2/21/2026 at 3:45 p.m. was unanswered and was not returned prior to the survey exit. During a concurrent interview and record review on 2/21/2026 atˆ11:45 a.m. with the Director ofˆStaffˆDevelopmentˆ(DSD), the DSD reviewed Resident 1's COCs, lab results report dated 10/10/2025 and progress notes from 10/10/2025 to 2/21/2026. The DSD stated the lab results report for Depakote indicated a value >150 mcg/ml and was flagged in red as HH, indicating a dangerously and critically high level. The DSD stated that a COC should have been completed and that RP1 should have been notified, as RP 1 is responsible for overseeing the resident's care. During a review of the facility providedˆpolicy and procedure (P&P)ˆtitled, Resident Rights last reviewed on 12/3/2025, the P&Pˆindicatedˆthe facility must ensure resident rights are not violated. The P&P indicated the resident has the right to be fully informed of their total health status and be afforded the opportunity to participate on an immediate and on-going basis in their total plan of care. During a review of the facility providedˆP&Pˆtitled, Change of Condition - Resident last reviewed on 12/3/2025, the P&Pˆindicated all occurrences resulting in a resident's change in condition must be documented in the medical records and parent/legal representative will be notified as soon as possible.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure confidential personal information of residents were protected by failing to ensure meal tickets ˆcontaining protected information ([PHI]- any health information that can be used to identify specific individualˆwhich must remain confidential to prevent harmful consequences) were shredded prior to disposing in the trash receptable for two of six residents (Resident 5 and Resident 35) who receive food from the kitchen. Thisˆfailure had the potential to violate the residents' rights to privacy and confidentiality of personal and medical records.ˆˆˆFindings:ˆˆˆ a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident to the facility on 3/17/2022 with diagnoses that included osteochondrodysplasia (a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, two short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder). During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 5's cognition (a mental process of acquiring knowledge and understanding through thought, experience and senses) was severely impaired. The MDS indicated Resident 5 required setup or clean-up assistance with eating and substantial/maximal assistance with oral hygiene, toileting hygiene, and required partial/moderate assistance with personal hygiene. During an observation on 2/21/2026 at 12:45 p.m., in the Activity/Dining room observed Resident 5 eating lunch. Observed Resident 5's lunch meal tray without a meal ticket. b. During a review of Resident 35's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing). During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touching assistance with eating, oral hygiene, toileting hygiene, and independent with personal hygiene. During an observation on 2/21/2026 at 12:46 p.m., in the Activity/Dining room observed Resident 35 eating lunch. Observed Resident 35's lunch meal tray without a meal ticket. During a concurrent observation, interview and record review on 2/21/2026 at 12:47 p.m., with Activities Assistant (AA), the AA was asked where Resident 5 and Resident 35's meal tickets were located. Observed the AA reach in the trash receptacle and pulled out two meal tickets. The AA reviewed the meal tickets and stated that the meal tickets contain resident information and that the facility had been discarding the meal tickets in the trash. The AA further stated that she was not aware that meal tickets containing resident information should not be disposed of in the trash receptacle. During an interview on 2/21/2026 at 12:47 p.m. with Licensed Vocational Nurse 3 (LVN), LVN 3 stated that licensed nurses dispose of the meal tickets in the trash receptacle. During a concurrent interviewˆand record review on 2/21/2026 at 1:46 p.m. with the Dietary Supervisorˆ(DS), the DSˆstatedˆthe meal ticket contain resident informationˆincluding the resident's name, menu, and room number. The DS reviewed a facility meal ticket and stated that at the bottom of the meal ticket, the meal ticket slip indicated, Please Return to Kitchen. The DS stated it was not appropriate to throw the meal ticketsˆin the trash because ofˆHealth Insurance Portability and Accountability Actˆ([HIPPA],ˆa law that sets national standard to protect sensitive health information, making sure it stays private and secure)ˆlaw. The DS continued to state that meal tickets should not be disposed of in the trash but should be shredded. During a review of the facility's (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	policy and procedure (P&P) titled Retention and Destruction, with review date of 12/5/2025, the P&P indicated copies of resident's protected health information (PHI), retained temporarily, are no longer needed, shall be properly destroyed to maintain information privacy. During a review of the facility's P&P titled HIPPA Privacy Compliance Statement, with review date of 12/5/2025, the P&P indicated the facility shall train all member of the workforce on the privacy policies and procedures with respect to protect health information (PHI) to carry out their function within the facility.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide the necessary services to maintain good grooming and personal hygiene for three of three sampled residents (Resident 10 and Resident 5) by failing to: 1.Ensure Resident 10 was provided oral care in accordance with the facility policy and procedure (P&P) titled Oral Hygiene, reviewed 12/3/2025, which indicated Each resident will be provided proper oral hygiene daily, beginning in the morning, after every meal, beforeˆbedtime, and as needed to maintain a healthy oral cavity and prevent complications of poor oral hygiene.ˆ This deficient practice placed the resident at risk for oral infections and tooth decay.2. Ensure Resident 5 and Resident 35's nails were trimmed.This deficient practice placed the resident at risk for skin injury or scratches, infection, and may cause discomfort and affect the resident's overall being. Findings: 1.During a review of Resident 10's admission Record (AR), the AR indicated that the facility admitted the resident on 3/07/2024, with diagnoses including encephalopathy (a disturbance of brain function) and encounter for attention to gastrostomy (aˆG tube to provide nutrition or medication because the patient can't swallow liquids or food normally).ˆˆ During a review of Resident 10's Minimum Data Set (MDS - a resident assessment tool) dated 12/15/2025, the MDS indicated that theˆresident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired.ˆ The MDS indicated that Residentˆ10ˆwasˆtotally dependentˆon staff for self-care.ˆˆ During an interview onˆ02/21/2026ˆatˆ8:40ˆa.m., with Resident 10`s Family Member 1 (FMˆ1), FMˆ1ˆstatedˆthatˆshe has concernsˆregarding the resident's oral care because she had observed debris accumulated in the resident's mouth, which may have resulted from the resident's teeth not being brushed. During a concurrent interview and record review onˆ02/21/2026 11:59ˆa.m., with Registered Nurse 2 (RN 2), reviewed Resident 10`sˆDocumentation Survey Report on oral care. RN 2 stated that the Documentation Survey Report on oral care did not indicate oral care was provided on 2/2/2026, 2/4/2026, 2/5/2026 and 2/6/2026 during the 7am-7pm shift.ˆRN 2ˆstatedˆifˆresidentsˆdo not receive oral care, the residents are at risk for developing oral infections and tooth decay. During a review of the facility`s policy and procedure (PP) titled Oral Hygiene, last reviewed on 12/3/2025, the PP indicated that Each resident will be provided proper oral hygiene daily, beginning in the morning, after every meal, beforeˆbedtime, and as needed to maintain a healthy oral cavity and prevent complications of poor oral hygiene.ˆ 2. a. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted Resident 5 on 3/17/2022 with diagnoses that includedˆosteochondrodysplasiaˆ(a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder).ˆ During a review of Resident 5's Minimum Data Set (MDS-a resident assessment tool) dated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/18/2025, the MDS indicated Resident 5's cognition (a mental processˆofˆacquiringˆknowledge and understanding through thought,ˆexperienceˆand senses) wasˆseverely impaired. The MDS indicated Resident 5 required setup or clean-upˆassistanceˆwith eating and substantial/maximalˆ(helper does more than half the effort) assistanceˆwith oral hygiene, toileting hygiene, andˆrequiredˆpartial/moderateˆ(helper does less than half the effort) assistanceˆwith personal hygiene.ˆ During an observation on 2/21/2026 at 8:55 a.m. in Resident 5's room,ˆobservedˆResident 5'sˆfingernailsˆto be long and untrimmed.ˆ During a concurrent observation and interview onˆ2/21/2026 at 5:33 p.m. with the Director of Staff Development (DSD), in Resident 5's room, the DSDˆobservedˆResident 5's fingernails. The DSDˆstatedˆthat Resident 5's fingernails are longˆpast fingertips, with sharp and uneven edges. The DSDˆstatedˆthat Resident 5's fingernails should be trimmed and filed.ˆ b. During a review of Resident 35's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included congenital malformation (an abnormal, faulty, or imperfectly formed structure of a body part or organ, often present at birth) syndrome, paralysis of vocal cords and larynx (a condition where one or both vocal folds [cords] in the larynx [voice box] cannot move due to damaged nerves), and stenosis of larynx (abnormal narrowing of the voice box which disrupts the flow of air to the lungs and can impair speech and breathing). During a review of Resident 35's MDS dated [DATE], the MDS indicated Resident 35's cognition was severely impaired. The MDS indicated Resident 35 required supervision or touching assistance with eating, oral hygiene, toileting hygiene, and independent with personal hygiene. During an observation on 2/21/2026 at 8:56ˆa.m. in Residentˆ35's room,ˆobservedˆResidentˆ35's fingernails to be long and untrimmed.ˆ During a concurrent observation and interview on 2/21/2026 at 5:34ˆp.m. with the DSD, in Residentˆ35'sˆroom, the DSDˆobservedˆResidentˆ35's fingernails. The DSDˆstatedˆthat Residentˆ35'sˆfingernailsˆare longer than they should be. The DSDˆstatedˆthat resident's' nailsˆextended past the fingertips and that the fingernails should be trimmed and filed to for resident safety. The DSD continued toˆstateˆthat it is the responsibility of all nursing staff to provide nail care to the residents.ˆˆ During a review of the facility'sˆpolicy and procedure (P&P) titled Nail Care, reviewed 12/5/2025, the P&P indicated nail care for residents should be performed weekly and/or as needed by daily/nightly assigned Licensed Nursing Staff (LNS)/Certified Nursing Assistants (CNA). Fingernails of residents are to be cut as needed. Length of nail is not to extend past tip of digits. Nails to be clipped/filed straight across. Use nail file to gently and carefully clip or file sharp jagged edges.ˆThe designated staff to document time,ˆdate,ˆhow procedure was tolerated,ˆand condition of hands feet and nails

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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 Registered Nurse (RN 1) maintained current CPR (cardio-pulmonary resuscitation - an emergency, life-saving technique performed when someone's breathing or heartbeat has stopped) certification for healthcare providers through a CPR provider whose training includes a hands-on session in accordance with accepted national standards for one of five staff members investigated during review of the staffing facility task. This deficient practice had the potential for delayed provisions of emergency care, including CPR to residents who wish to have full treatment in life threatening illnesses or injuries. Findings: During an employee file review on [DATE] at 2:15 p.m. with Human Resources staff 1 (HR 1), HR 1 reviewed RN 1's employee file. HR 1 stated RN 1's CPR certification was all web based without the required in person hands on component. During an interview on [DATE] at 5:15 p.m. with RN 1, RN 1 stated she was sorry and she did not know a hands-on component was required for return demonstration and compliance for CPR certification. RN 1 stated the CPR course was completely web-based. During an interview on [DATE] at 5:34 p.m. with Director of Staff Development (DSD), the DSD stated according to facility policy, all CPR certifications must have a hands-on component to test out what the staff learned and to ensure CPR is performed correctly. During a review of the facility`s policy and procedureˆ(P&P)ˆtitled Verification of Licenses and/or Credentials Required Certifications last reviewed onˆ[DATE]ˆtheˆP&Pˆindicatedˆthatˆthey would employ only those that have provided proper certifications and shall be maintained and kept current. ˆThe policy indicated a current BLS card is required of all clinical personnel, including registered nurses, and must be renewed every two years. The policy further indicated BLS classes were offered in person at the facility.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to implement a bowel (tube-shaped organ in the abdomen that completes the process of digestion) and bladder (a hollow organ that stores urine) training program (B&B retraining program - aim to establish or regain control over bowel and bladder function) for one of two sampled residents (Resident 5) by failing to ensure Resident 5 was placed on the toilet every two hours per physician's order.^ This deficient practice had the potential for Resident 5 to not their highest functional level and not establish or regain control over bowel and bladder function.Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 3/17/2022 with diagnoses that included osteochondrodysplasia (a group of rare, typically genetic, disorders that cause abnormal development of bone and cartilage, resulting in stunted growth, short stature, and skeletal deformities), other congenital (a trait, disorder, or condition that is present at or before birth) deformities of skull, face, and jaw, and hydronephrosis (the swelling of one or both kidneys caused by a buildup of urine that cannot drain properly into the bladder). During a review of Resident 5's Minimum Data Set (MDS- a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 5's cognition (a mental process of acquiring knowledge and understanding through thought, experience and senses) was severely impaired. The MDS indicated Resident 5 required setup or clean-up assistance with eating and substantial/maximal assistance with oral hygiene, toileting hygiene, and required partial/moderate assistance with personal hygiene. The MDS indicated that Resident 5 is currently in a toileting program (a structured, planned routine designed to help a person [child or adult] gain or regain control over bladder and bowel habits). During a review of Resident 5's Order Summary Report, the Order Summary Report indicated for bowel and blader training: Place resident on toilet every two (2) hours while awake for 2 minutes. Certified Nursing Assistants (CNAs) to document method used result. Order date: 7/7/2025. During a review of Resident 5's care plan (a document that summarizes a resident's needs, goals, and care/treatment) initiated on 9/3/2025, the care plan indicated Resident 5 is participating in a Bowel & Bladder training program. Interventions indicated nursing staff to assist resident to the toilet/commode (a portable, chair-like toilet with a removable basin for people with limited mobility) /toddler potty chair every 2 hours while awake and as needed. Document method used. During a concurrent interview and record review on 2/21/2026 at 7:00 p.m., with the Director of Staff Development (DSD), reviewed Resident 5's medical records, nursing progress notes and CNA tasks for the month of 1/2026 to present. The DSD stated that Resident 5 is in a bowel and bladder training program. The DSD stated that Resident 5 is to be placed on the toilet every two (2) hours to help train Resident 5 to use the toilet. The DSD stated when staff place Resident 5 on the toilet, staff are to document in Resident 5's medical record. The DSD stated that there was no documented evidence that Resident 5 was placed on the toilet on the following days: 1/6/2026; 1/10/2026; 1/18/2026; 1/19/2026; 1/20/2026; 1/25/2026; 2/14/2026; 2/15/2026; 2/19/2026; and 2/21/2026. The DSD continued to state that based on the documentation, staff did not place Resident 5 on the toilet as ordered. The DSD stated staff should have placed Resident 5 on the toilet every two (2) hours and document their efforts. The DSD further stated it is important to toilet train Resident 5 because of his age and for his health and well-being. During a review of the facility's policy and procedure (P&P) titled, Bowel and Bladder Evaluations - Incontinence, reviewed 12/5/2025, the P&P indicated nursing measures will be employed to prevent and reduce incontinence (a problem holding in urine or stool) for each resident. Licensed Nurse Staff (LNS) to evaluate the residents' performance in the bowel and bladder management program on the weekly summary. Daily recording of intake and output of all residents unless fully trained. Review and report at each IDT (Interdisciplinary Team- a group of professionals from different fields who work together closely, sharing knowledge to provide comprehensive care) care plan for appropriate input and output.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1.Obtain and document the weight of two of five residents (Resident 4 and Resident 32) reviewed under the nutrition care area in accordance with the physician's order. This deficient practice had the potential to prevent staff from identifying significant weight changes and addressing potential nutritional concerns. 2. Ensure the total volume of water to be infused via gastrostomy tube (G-tube, a feeding tube inserted through the abdomen to provide nutrition, fluids, and medications) was documented on the water bag label for one of three residents (Resident 22) reviewed under the hydration care area, in accordance with the physician's order. This deficient practice had the potential for staff to be unaware of the amount of water to be infused per the physician's order, placing the resident at risk for fluid imbalance (a condition that occurs when the body has too much or too little fluid, disrupting the normal balance needed for the body to function properly). Findings: 1.During a review of Residentˆ4'sˆadmission Record, the admission Recordˆindicatedˆthe facility admitted Resident 4ˆ the facility onˆ 1/22/2019ˆ and readmitted on [DATE] withˆdiagnosesˆincluding tracheostomyˆ(a surgical procedure that creates an opening in the neckˆleading directly into the tracheaˆ[windpipe])ˆdependence on a ventilatorˆ(a medical machine that helps a patient breathe or completely takes over their breathing when they cannot do so on their own) and seizures (a suddenˆsurge of abnormal electrical activity in the brain, leading to a range of symptoms like muscle spasms, loss of consciousness).ˆ During a review of Residentˆ4's Minimum Data Set (MDS-a standardized assessment and care screening tool) datedˆ1/25/2026, the MDS indicated Resident 4 is in a persistent vegetative stateˆ(whenˆpatients are awake but have no awareness of themselves orˆofˆtheir surroundings). The MDS furtherˆindicatedˆResidentˆ4ˆwas completely dependent (helper does all the effort) on facility staff for all activities of daily livingˆ(ADLs- activities such as bathing, dressing and toileting a person performs daily)ˆˆ ˆ During a review of Resident 4's Order Summary Report printed on 2/21/2026, the Order Summary Report indicated the following orders dated 12/30/2025: – weigh weekly x4 (four) weeks on admission/readmission then weigh monthly thereafter. – weigh before the 12:00 p.m. feeding (tube feeding) every day shift every Mon (Monday) for weight management. During a review of Resident 4's weights during the month of January 2026 there was not a weight recorded on Monday, 1/19/2026 or the week of 1/19/2026 in accordance with the physician's order. During a concurrent interview and record review onˆ2/21/26ˆatˆ4:26ˆp.m.ˆ withˆthe Director ofˆStaffˆDevelopment, (DSD), the DSDˆreviewed Resident 4's physician's orders and weekly weights. The DSD stated that the physician's order to obtain weekly weights was not followed because the resident's weight was not taken on 1/19/2026. The DSD stated that accurate weights are extremely important in pediatric residents because the amount of medication and food given to pediatric residents is based on their weight. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility`s policy and procedureˆ(P&P)ˆtitled Physician Orders last reviewed onˆ12/3/2025ˆtheˆP&Pˆindicated thatˆthe physician would give orders for medication, treatment., All orders must be carried out completely. ˆˆ  During a review of the facility`s P&Pˆtitled Monthly Weight Procedure last reviewed onˆ12/3/2025ˆtheˆP&Pˆindicated for residents on weekly or more frequent weights, any weight changes may be significant, and the licensed nurse must evaluate and report cumulative weight changes. b. During a review of Residentˆ32'sˆadmission Record, the admission Recordˆindicatedˆthe facility admitted Resident 32ˆto the facility onˆ10/8/2012ˆand withˆdiagnosesˆincluding tracheostomy, dependence on a ventilatorˆand epilepsy (a chronic brain disorder characterized by a tendency to have recurrent, unprovoked seizures).ˆ During a review of Residentˆ32's Minimum Data Set (MDS-a standardized assessment and care screening tool) datedˆ1/3/2026, the MDS indicated Resident 32 was in a persistent vegetative state. The MDS furtherˆindicatedˆResidentˆ32ˆwas completely dependent on facility staff for all activities of daily living. During a review of Resident 32's Order Summary Report printed on 2/21/2026, the Order Summary Report indicated an order dated 12/30/2025 to weigh Resident 32 weekly x4 (four) weeks on admission/readmission then weigh monthly thereafter. During a concurrent interview and record review onˆ2/21/26ˆat 4:32ˆp.m.ˆwithˆthe DSD, the DSD reviewed Resident 32's physician's orders and monthly weights. The DSD stated that the physician's order to obtain weekly weights was not followed because the resident's weight was not taken for the month of June 2025. The DSD stated that accurate weights are extremely important in pediatric residents because the amount of medication and food given to pediatric residents is based on their weight. During a review of the facility`s P&Pˆtitled Monthly Weight Procedure last reviewed onˆ12/3/2025ˆtheˆP&Pˆindicated records of weight loss/gain must be maintained monthly. ˆ 2. During a review of Resident 22's admission Record, the admission Record indicated that the facility admitted the resident on 8/20/2019, with diagnoses including anoxic brain damage (occurs when the brain is completely deprived of oxygen for more than roughly four minutes, causing rapid cell death and significant, often permanent, injury) and encounter for attention to gastrostomy. During a review of Resident 22's Minimum Data Set (MDS - a resident assessment tool) dated 01/21/2026, the MDS indicated that the resident is comatose (a deep, prolonged state of unconsciousness, unable to wake up or respond to their environment, even to pain or sound, with minimal brain activity). The MDS indicated that Resident 22 was totally dependent on staff for self-care. During a review of Resident 22's Physician Order Summary Report, the Order Summary Report indicated an order dated 04/27/2025, to flush 170 milliliters (ml-measurement of volume) of water via GT pump (machine that delivers liquid nutrition, water or medication through a G-tube) six times a day (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for hydration. During a concurrent observation and interview on 02/20/2026 8:31 p.m.,ˆin Resident 22's room, with Licensed Vocational Nurse 5 (LVN 5), observedˆan empty water bag hanging on a pole connected to a GT feeding pump next to Resident 22`s bedside. LVN 5ˆstatedˆthat she hung the bag this morning and acknowledged that the sticker attached to the bag, where the date, time, nurse's initials, and the amount of water to be infused were to be documented, was blank. LVN 5ˆstatedˆthe nurses during the day shift should have documented the amount of water infused via the resident's G-tube in the sticker to indicate the total amount of water administered to the resident from 7 a.m. to 7 p.m. LVN 5 stated that it is important to document the amount of fluid on the water bag label to ensure the resident receives the volume of water ordered by the physician. LVN 5 stated that not labeling the bag with the total amount of water administered to the resident had the potential for licensed nurses to be unaware of how much water had already been given. This could result in the resident not receiving the ordered amount of fluid, placing the resident at risk for dehydration (occurs when the body uses or loses more fluids than it takes in) and urinary tract infections (UTI, an infection in any part of the urinary system). During an interview onˆ02/21/2026 2:24ˆp.m.ˆwith Registered Nurse 2, reviewedˆResident 22`s care plan (CP) addressing the risk for dehydrationˆdeveloped on 4/24/2024,ˆthe CP included an intervention toˆprovide 170ˆmilliliters (ml) of water via GT pump six times a day for hydration. RN 2ˆstatedˆthat it is important toˆdocument the amount of water administered to the resident to ensure nurses are aware of how much water has been given. RN 2 stated that if the resident does not receive enough water, it may increase the resident's risk for dehydration, which could result in urinary tract infection. During a review of the facility`s policy and procedure (PP) titled Resident Care Planning, last reviewed on 12/3/2025, the PPˆindicatedˆthat A comprehensive plan of care will be developed to meet each resident`s medical,ˆdevelopmentalˆand psychosocial needs. This care plan will include the problems/needsˆidentifiedˆin the Resident Assessment Instrument as well as other problems/needs asˆidentifiedˆby the staff,.ˆ During a review of the facility's P&P titled, Enteral Tube Feeding: Gastrostomy ., last reviewed on 12/3/2025, the PP indicated that open system water bags are used when prescribed by the physician.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on interview and record review the facilityˆfailed to ensure the facility's policy and procedure (P&P) titled, Medication Administration, reviewed 12/3/2025, was followed for one of eight residents (Resident 1) observed during medication administration, when Licensed Vocational Nurse 4 (LVN 4) failed to check placement of Resident 1's gastrostomy tube (G-tube, a tube inserted through the abdomen, to deliver nutrition and medications directly to the stomach) prior to administration of medications. This deficient practice had the potential to place Residentˆ1ˆat increased riskˆforˆaspiration pneumoniaˆ(a type of lung infection that occurs when food, saliva, or other substances are inhaled into the lungs,ˆwhich occurs when medication is accidentally delivered into the lungs instead of the stomach because an improperly placed tube could be in the esophagus or trachea, allowing medication to enter the airway).ˆ Findings: During a review of Resident 1 's admission Record, theˆadmission Record ˆindicatedˆthat the facilityˆadmitted the resident onˆ7/17/2024ˆwith diagnoses includingˆepilepsy (a brain condition that causes recurring seizure) and gastrostomy status (the presence of a surgically created opening (stoma) in the stomach used for long-term enteral nutrition or gastric decompression in patients unable to ingest sufficient nutrients orally)ˆ During a review of Residentˆ1's Minimum Data Set ([MDS] - a resident assessment tool,) datedˆ1/26/2026, the MDS indicatedˆthe resident had severely impairedˆcognitionˆ(the mental action or process ofˆacquiringˆknowledge and understanding through thought, experience, and the senses)ˆˆand totally dependent on staff for activities of daily living(ADLs- activities such as bathing, dressing and toileting a person performs daily).ˆˆ During a review of Resident 1`sˆphysician orders, the physician orders indicated an order datedˆ9/15/2025 forˆMiralax (laxative)ˆ8.5 grams (Gm-unit of mass and weight)ˆvia G-Tube two times a day for constipation (problem with passing stool) and mix with 60 milliliters (ml-unit of volume) of water, hold for loose stools. During aˆconcurrent medication administration observation and interview onˆ02/21/2026ˆatˆ5:04ˆp.m.,ˆwith LVN 4, observedˆLVN 4 prepareˆ Miralaxˆby mixing it (Miralax) with 60ˆml of water. LVN 4ˆdonned gloves, gown and mask andˆproceeded to Resident 1's bedside.ˆ LVN 4 turned off Resident 1's enteral feeding pump, flushed the G-tube with five ml of water, administered Miralax, and flushed the G-tube with five ml of water after administration without verifying the placement of the G-tube. When LVN 4 was asked about verifying the placement of Resident 1's G-tube, LVN 4 stated she forgot to check the G-tube placement by aspirating for gastric residual to ensure the G-tube was in the stomach. During an interview onˆ02/21/2026ˆatˆ6:59ˆp.m., withˆRegistered Nurse 2 (RNˆ2), RN 2ˆstatedˆthat prior to medication administration via G-tube, the nurse should check theˆplacement by aspirating for gastric contents. RN 2ˆstatedˆthat if the G-tube is not in the stomach,ˆthe medications canˆseepˆinto the abdominal cavity and causeˆinfectionˆand trauma.ˆRN 2 further stated it is important to check G-tube placement to prevent aspiration pneumonia. During a review of the facility`s policy and procedure (PP) titled Medication Administration, last reviewed on 12/3/2025, the PP indicated that Medication Administered Via An Enteral Feeding Tube General Guidelines.Check enteral tube for placement using a syringe to administer an air bolus, while auscultating, then aspirate stomach contents, noting residual and removing previously inserted air.ˆ

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure seven medium-sized and six large-sized boxes of drinks and food items were not stacked higher than 18 inches from the ceiling in the dry storage area of the facility's kitchen. This failure had the potential to prevent water sprinkler clearance to reach the top of these boxes in the event of a fire and the potential for the boxes to fall and dent resulting in harmful bacteria growth for six of 37 medically compromised and vulnerable residents who received food from the kitchen. Findings: During an initial kitchen observation on 2/20/2026 at 6:15 p.m., observed in the dry storage area, seven medium-sized and six large-sized boxes on two different wire racks that were stacked greater than 18 inches from the ceiling. ^^ During a concurrent observation and interview on 2/21/2026 at 11:25 a.m., in the dry food storage area of the kitchen with the Dietary Supervisor (DS), the DS stated it is against the facility's policy to stack items greater than 18 inches from the ceiling and stated there were about 13 boxes total that were stacked greater than 18 inches. The DS stated there must be at least 18 inches for the water sprinkler on the ceilings to reach and put out a fire. The DS stated the boxes could also fall causing dents which could lead to bacteria grow. The DS stated the boxes must be stored correctly as soon as they get delivered. ^ During a reviewˆof the facility'sˆpolicy and procedure (P&P)ˆtitled,ˆ Food Storage/Preparation, last reviewed on 12/3/2025,ˆthe P&PˆindicatedˆthePfacility must store and secure food safely. ^

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555815	A. Building B. Wing	02/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Totally Kids Specialty Healthcare - Sun Valley	10716 LA Tuna Canyon Road Sun Valley, CA 91352

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facilityˆfailed toˆdispose garbage and refuse properlyˆby failing to: 1. Ensure two of two black dumpsters (a movable waste container designed to be brought and taken away by a special collection vehicle, or to a bin that a specially designed garbage truck lifts)ˆand one of one blue dumpster were completely closed while not actively being used. 2. Ensure there were no soiled gloves on the floor area and surroundings of the facility's dumpster.ˆ This deficient failure had potential to attract birds, flies, insects, pests, and possibly spread infection to 37 of 37 facility residents. Findings:ˆ ˆ During an observation on 2/21/2026 at 11:32 a.m., of the facility dumpster area with the Dietary Supervisor (DS),ˆobserved two blackˆdumpstersˆand one blue dumpster fully openˆand a pair of soiled gloves on the ground near the dumpsters.ˆˆˆ ˆˆ During an interview on 2/21/2026 at 11:34 a.m.,ˆwith the DS, the DSˆstatedˆall the trash must be inside the dumpster and dumpster lids shouldˆalways be closed.ˆThe DSˆstatedˆthe lids on the dumpsters must be closed and the area around the dumpsters must be cleaned and free of trash for infection control and to avoid animalsˆand pestsˆfrom gettingˆinto the trash.ˆThe DSˆstatedˆanimals and pests could come inside the facility and contaminate the food residents would receive. The DSˆfurther stated theˆdietary departmentˆis responsible forˆkeeping the dumpster lid closed.ˆ During a reviewˆof the facility'sˆpolicy and procedure (P&P)ˆtitled,ˆ Disposal of Infectious and Ordinary Waste Products, last reviewed on 12/3/2025,ˆthe P&Pˆindicatedˆthe facility will ensure all waste products will be disposed of properly and dumpster lids will be closed after every use.