STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Glen Care Center	638 E Colorado Avenue Glendora, CA 91740

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the call light (a device used by residents to call for assistance from staff) was within reach (an arm's length) for two of two sampled residents (Residents 5 and 69). These deficient practices had the potential to result in delayed provision of care and services and placed the residents at risk for falls/injury.Findings: a. During a review of Resident 69's admission Record (AR), the AR indicated Resident 69 was admitted to the facility on [DATE] with a diagnoses including dementia (a decline in mental abilities, including memory, thinking, language, and reasoning severe enough to interfere with daily life), Alzheimer's disease (a progressive, irreversible brain disorder leading to severe memory loss, and personality changes) and anxiety disorder (excessive fear or worry about a specific situation). During a review of Resident 69's History and Physical (H&P) dated 9/25/2025, the H&P indicated Resident 69 could make needs known but could not make medical decisions. During a review of Resident 69's Minimum Data Set (MDS- standardized assessment tool) dated 4/1/2026, the MDS indicated Resident 69 required supervision or touching assistance (helper provides verbal cues ad or touching steadying and or contact guard assistance as resident competes activity) for toileting hygiene, shower/bathe self, upper body dressing putting on/taking off footwear and personal hygiene. During a review of Resident 69's Fall Risk Evaluation (FRE) dated 4/9/2026, the FRE indicated Resident 26 was high risk for falls. During initial observation inside Resident 69's room on 5/5/2026 at 9:12 AM, Resident 69 was in bed, resting on the right side and the call light was not within reach. The call light was hanging on the wall behind Resident 69's bed. During a concurrent observation and interview inside Resident 69's room on 5/5/2026 at 12:36 pm, Resident 69 was sitting up on the right side of the bed eating lunch. Resident 69's call light was not within reach. The call light was still hanging on the wall behind Resident 69's bed. Resident 69 stated, I don't know where my call light is, I don't see it anywhere. If I need help, I'll just have to scream until someone comes. During a concurrent observation and interview inside Resident 69's room on 5/6/2026 at 10:52 AM, Certified Nursing Assistant 3 (CNA 3) stated Resident 69's call light was not within Resident 69's reach. CNA 3 stated the call light should always be placed next to the resident's hands so the resident could call when they needed to be cleaned or if they needed to go to the bathroom. CNA 3 stated the resident could suffer a fall if the call light was not within reach and the resident could not call for (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	help. During an interview with the Director of Nursing (DON) on 5/6/2026 at 10:41 AM, the DON stated the resident's call light should be within arm's reach. The DON stated if the call light was not within reach, then the resident won't be able to call for assistance. The DON stated if the resident could not call for assistance, the resident could suffer a fall/ accident or injury. During a review of the facility's undated Policy and Procedure (P&P) titled, Call Light/Bell, the P&P indicated Place the call device within resident's reach before leaving the room. b. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 3/21/2026 and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (GT, tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) status. During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/26/2026, the MDS indicated, Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 needed maximum assistance (helper does more than half the effort) from staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing and putting on/taking off footwear. During a review of Resident 5's untitled Care Plan (CP) revised on 4/7/2026, the CP indicated Resident 5 was at risk for falls related to confusion and being unaware of safety needs. The CP intervention indicated for nursing staff to ensure Resident 5's call light was within reach and encouraged Resident 5 to use it for assistance as needed. The CP intervention indicated Resident 5 needed prompt response to all requests for assistance. During an observation inside Resident 5's room on 5/5/2026 at 8:47 am, Resident 5 was awake, lying in bed. Resident 5's call light was hanging on the right side of the bed rail touching the floor. During a concurrent observation inside Resident 5's room and interview on 5/5/2026 at 8:49 am with Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, Resident 5's call light was on the floor and Resident 5 was unable to reach it. LVN 2 stated Resident 5's call light needed to be accessible at all times for Resident 5's safety and for staff to be able to provide care when Resident 5 needed help. During an interview on 5/6/2026 at 3:04 pm with the Director of Nursing (DON), the DON stated the residents' call light needed to be accessible and within reach by the residents at all times for them to ask help from the staff for assistance or in case of an emergency. During a review of the facility's undated Policy and Procedure (P&P) titled, Call Light/Bell, the P&P indicated Place the call device within resident's reach before leaving room.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of two sampled residents' (Residents 91 and 98) Minimum Data Set (MDS, a resident assessment tool) reflected an accurate assessment by failing to: a. Ensure Resident 91's diagnosis of anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry) was coded in MDS assessment dated [DATE]. b. Ensure Resident 98, who was discharged to home under the care of home health (wide range of health care services that could be given at home for an illness or injury) service was coded in the MDS assessment dated [DATE], accurately. These deficient practices resulted in inaccurate reporting to the Centers of Medicare and Medicaid (CMS, a federal agency that administers the Medicare program and work with state governments to administer the Medicaid and health insurance portability standards) agency and had the potential to result in Residents 91 and 98 not receiving interventions to address specific care concerns.Findings: a. During a review of Resident 91's admission Record (AR), the AR indicated the facility admitted Resident 91 on 6/26/2025 with diagnoses including amnesia (sudden loss of memory) and anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry). During a review of Resident 91's History and Physical (H&P) dated 11/5/2025, the H&P indicated Resident 91 had the capacity to understand and make decisions. During a review of Resident 91's Psychiatric Progress Note (PPN) dated 3/23/2026, the PPN indicated Resident 91 had a diagnosis of anxiety disorder. During a review of Resident 91's Physician Order (PO) dated 3/23/2026, the PO indicated Resident 91 had an active order of buspirone HCL (medication for anxiety disorder) twice a day. During a review of Resident 91's MDS dated [DATE], the MDS indicated Resident 91 had intact cognition (ability to understand and process information). The MDS indicated Resident 91 required setup assistance from staff with eating and oral hygiene. The MDS indicated Resident 91 required supervision from staff with toileting hygiene and showering/ bathing. The MDS indicated Resident 91 required moderate assistance (helper did less than half the effort) from staff with personal hygiene. The MDS indicated Resident 91 required maximal assistance (helper did more than half the effort) from staff with bed-to-chair transferring. During a concurrent record review and interview with MDS Nurse 1 (MDSN 1) on 5/8/2026 at 9:50 AM, Resident 91's Medication Administration Record (MAR) for March 2026 was reviewed. MDSN 1 stated the MAR indicated Resident 91 received buspirone HCL for anxiety disorder starting on 3/23/2026. During a concurrent record review and interview with MDSN 1 on 5/8/2026 at 9:50 AM, Resident 91's MDS dated [DATE] was reviewed. MDSN 1 stated the MDS dated [DATE] did not indicate Resident 91 had a diagnosis of anxiety disorder. MDSN 1 stated anxiety disorder should have been coded in Resident 91's MDS because Resident 91 was taking buspirone HCL for anxiety starting on 3/23/2026. MDSN 1 stated that the MDS should be modified and resubmitted to CMS. b. During a review of Resident 98's AR, the AR indicated the facility admitted Resident 98 on 2/15/2026 with diagnoses including sepsis (a life-threatening blood infection) and hypertension (high blood pressure). During a review of Resident 98's H&P dated 2/16/2026, the H&P indicated Resident 98 had the capacity to understand and make decisions. During a review of Resident 98's PO dated 3/3/2026, the PO indicated to discharge Resident 98 to home with home health for wound follow up. During a review of Resident 98's MDS dated [DATE], the MDS indicated Resident 98 had intact cognition. The MDS indicated Resident 98 required setup assistance from staff with eating and oral hygiene. The MDS indicated Resident 98 required moderate assistance from staff with toileting hygiene, showering/ bathing, personal hygiene, and bed-to-chair transferring. During a review of Resident 98's Physician's Discharge Summary (PDS) dated 3/9/2026, the PDS indicated the facility discharged Resident 98 home with home health because Resident 98 no longer needed the services provided by the facility. During a concurrent record review and interview with MDS Coordinator (MDSC) on 5/7/2026 at 9:17 AM, Resident 98's MDS dated [DATE] was reviewed. The MDSC stated the MDS (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated Resident 98 was discharged to home/community instead of discharged home under care of organized home health service organization. The MDSC stated Resident 98's MDS was not an accurate assessment. The MDSC stated the facility transcribed the resident's assessment to CMS. The MDSC stated it was important to have an accurate MDS assessment because the MDS assessment was a reflection of the overall residents' care and the services provided to the residents. The MDSC stated the MDSC certified the assessment accuracy by signing the MDS assessment. The MDSC stated an inaccurate MDS assessment did not provide the correct residents' information to CMS. During an interview on 5/8/2026 at 8:41 AM with the Director of Nursing (DON), the DON stated it was important to have an accurate MDS assessment because the facility needed to provide accurate information to CMS. The DON stated the MDS assessment should indicate resident's diagnoses and discharge destination accurately. During a review of the facility's Policy and Procedure (P&P) titled, Minimum Data Set (MDS) Coordinator Policy & Procedure, dated 1/1/2026, the P&P indicated the facility should complete all MDS assessments accurately in compliance with federal and California state regulations. The P&P indicated the MDSC was responsible for ensuring all assessments reflect the resident's current clinical status. The P&P indicated that the MDSC was responsible for ensuring the accuracy of coding through chart review and correcting errors promptly. The P&P further indicated that the DON was responsible for reviewing MDS accuracy.

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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 specific, comprehensive, and individualized person-centered care plans (CP) to meet the residents' needs for three of three sampled residents (Residents 1, 85, and 91) by failing to: a. Develop an individualized CP to address the use of namenda (medication to improve memory, awareness, and daily functioning) for Resident 91. b. Follow the CP to maintain the appropriate setting for Resident 1's low air loss mattress (LALM - a specialty bed that alternates pressure to help heal and prevent pressure ulcers/injuries [localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence]). c. Follow the CP for Resident 85's pressure ulcer treatment and LALM. These failures resulted in the residents not receiving individualized care to maintain the residents' highest practicable physical, mental, and psychosocial well-being. a. During a review of Resident 91's admission Record (AR), the AR indicated the facility admitted Resident 91 on 6/26/2025 with diagnoses including amnesia (sudden, loss of memory) and anxiety disorder (mental health condition characterized by persistent, excessive, and uncontrollable fear or worry). During a review of Resident 91's History and Physical (H&P) dated 11/5/2025, the H&P indicated Resident 91 had the capacity to understand and make decisions. During a review of Resident 91's Minimum Data Set (MDS, a resident assessment tool) dated 3/27/2026, the MDS indicated Resident 91 had intact cognition (ability to understand and process information). The MDS indicated Resident 91 required setup assistance from staff with eating and oral hygiene. The MDS indicated Resident 91 required supervision from staff with toileting hygiene and showering/ bathing. The MDS indicated Resident 91 required moderate assistance (helper did less than half the effort) from staff with personal hygiene. The MDS indicated Resident 91 required maximal assistance (helper did more than half the effort) from staff with bed-to-chair transferring. During a review of Resident 91's Physician Order (PO) dated 4/9/2026, the PO indicated Resident 91 had an active order of namenda 5 milligrams (mg- unit of measurement) twice a day for dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a concurrent record review and interview with the Director of Nursing (DON) on 5/8/2026 at 8:41 AM, Resident 91's entire care plans were reviewed. The DON stated there was no CP developed to address Resident 91's use of namenda. The DON stated the licensed nurse who received the namenda order should have developed the specific CP for Namenda for Resident 91. The DON stated the CP needed to be specific and resident-centered to address the specific diagnosis and medications. During a review of the facility's undated Policy and Procedure (P&P) titled, Care Planning, the P&P indicated the facility should develop a comprehensive care plan for each resident within seven days of completion of the resident's MDS. During a review of the facility's P&P titled, Minimum Data Set (MDS) Coordinator Policy & Procedure, dated 1/1/2026, the P&P indicated that the MDS Coordinator was responsible for ensuring all care plans reflect the resident's current clinical status. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 1's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including but not limited to cerebral infarction (stroke, loss of blood flow to a part of the brain), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and cognitive communication deficit (communication difficulty caused by impaired thinking skills). During a review of Resident 1's progress note, dated 4/26/2026, the progress note indicated Resident 1 has the capacity to make needs known. During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 1 has moderate impairment of thinking and memory. The MDS indicated Resident 1 has one-sided impairment to upper and lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). The MDS also indicated Resident 1 is at risk for developing PUs. During a review of Resident 1's weight log, dated 5/7/2026, the weight log indicated Resident 1's most recent weight, taken on 4/5/2026, was 119 pounds. During an observation on 5/5/2026 at 9:33 AM in Resident 1's room, Resident 1 was lying in her bed asleep. Resident 1 had a LALM in place that was turned on. The setting on the LALM control panel was set to 210 pounds. During an interview on 5/5/2026 at 10:21 AM with Treatment Nurse (TN) 1, TN 1 stated Resident 1's LALM should not be set at 210 pounds. The correct setting should be the resident's most recent weight, which is 119 pounds. During a concurrent interview and record review on 5/7/2026 at 10:00 AM with TN 1, Resident 1's physician's order, dated 4/13/2026, was reviewed. The physician's order indicated Resident 1 may have a LALM for wound management and to check for the placement, function, and setting of the LALM every shift. TN 1 stated it is the TN's responsibility to do rounds every morning to make sure the LALM is at the correct setting. If the LALM is left at the incorrect setting, it could lead to wound decline, delayed healing, or the development of a new PU. The order to monitor the LALM was not followed for Resident 1 because her LALM was at the incorrect setting. During a concurrent interview and record review on 5/7/2026 at 10:01 AM with TN 1, Resident 1's care plan titled, The Resident is at Risk for Further Skin Breakdown., last revised on 4/17/2026, was reviewed. The care plan indicated Resident 1 may have a LALM for wound management. The LALM should be monitored for placement, function, and setting. TN 1 stated the care plan was not followed because Resident 1's LALM was not at the correct setting. TN 1 further stated care plans outline the steps nursing must take to help residents improve. If not followed, the resident's wounds may deteriorate. During an interview on 5/7/2026 at 9:26 AM with the Minimum Data Set Coordinator (MDSC), the MDSC stated care plans help take care of the patient effectively. Care plans guide the care of the residents. If they are not followed, it could lead to the resident being hospitalized . During an interview on 5/7/2026 at 3:01 PM with the Director of Nursing (DON), the DON stated it is important to have LALMs be at the correct setting to ensure that they treat wounds and promote their healing or prevent new wounds from being formed. If the LALM is not at the appropriate setting, it (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could create a new wound or make the existing wound worsen. The DON further stated it is important to ensure care plans are followed because they tell nursing staff what they are supposed to and guide the care of the residents. During a review of the facility's LALM operator manual titled, Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System, undated, the manual indicated the LALM setting should be set at the patient's weight. During a review of the facility's policy and procedure (P&P) titled, Alternating Pressure Pad or Mattress, undated, the P&P indicated the facility may use specialized mattresses to prevent skin breakdown and to treat PUs of residents. During a review of the facility's policy and procedure (P&P) titled, Care Plan and Care Plan Update, undated, the P&P indicated the facility must ensure each resident receives the care and services to attain and maintain their highest practicable wellbeing. The care plan will be initiated upon identification of a resident need that requires intervention or monitoring. c. During a review of Resident 85's face sheet, dated 5/7/2026, the face sheet indicated Resident 85 was admitted to the facility on [DATE] with diagnoses including but not limited to malnutrition (a condition of imbalance between the nutrients the body needs to function and the nutrition it gets), dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 85's history and physical (H&P), dated 3/5/2026, the H&P indicated Resident 85 does not have the capacity to understand and make decisions. During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 has severe problems with thinking or memory. The MDS indicated Resident 85 has one-sided impairment to upper and lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). The MDS also indicated Resident 85 is at risk for developing PUs and currently has PUs. During a review of Resident 85's physician's orders, dated 5/1/2026 at 4:41 PM, the order indicated treatment instructions for Resident 85's right hip stage 3 PU (full-thickness loss of skin; dead and black tissue may be visible). The instructions were to cleanse the wound, pat dry, apply antiseptic (a substance applied to skin or tissue to destroy germs), then cover with a dressing every day and as needed for soiled or dislodged dressings. During a review of Resident 85's physician's orders, dated 4/29/2026 at 5:32 PM, the order indicated treatment instructions for Resident 85's left fourth-finger stage 4 PU (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). The instructions were to cleanse the wound, apply ointment, then cover with a dressing every day and as needed for soiled or dislodged dressings. During a review of Resident 85's care plan titled, The Resident is at Risk for Further Skin Breakdown., last revised on 4/13/2026, the care plan indicated Resident 85 may have a LALM for wound management. The LALM should be monitored for placement, function, and setting. During a review of Resident 85's care plan titled, Resident has an Actual Pressure Ulcer Stage 3 on Right Hip, revised on 4/19/2026, the care plan indicated to keep the wound covered with a dressing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and administer treatments as ordered. During a review of Resident 85's care plan titled, Resident has an Actual Stage 4 Pressure Ulcer on Left 4th Finger, revised on 5/1/2026, the care plan indicated to keep the wound covered with a dressing and administer treatments as ordered. During a review of Resident 85's weight log, dated 5/7/2026, the weight log indicated Resident 85's most recent weight, taken on 4/5/2026, was 102 pounds. During an observation on 5/5/2026 at 9:26 AM in Resident 85's room, Resident 85 was lying in his bed asleep. Resident 85 had a LALM in place that was turned on. The setting on the LALM control panel was set to 200 pounds. During an interview on 5/5/2026 at 10:21 AM with TN 1, TN 1 stated Resident 85's LALM should not be set at 200 pounds. The correct setting should be the resident's most recent weight, which is 102 pounds. During a concurrent observation and interview on 5/6/2026 at 3:11 PM with TN 1 and TN 2 in Resident 85's room, Resident 85's treatment was being performed for the right hip stage 3 PU. There was no dressing in place on the wound. The right hip stage 3 PU was red and had some scabs starting to form. TN 2 stated there was no dressing in place on the wound before starting the treatment. TN 1 stated there is a physician's order to keep the wound covered with a dressing and this physician's order was not carried out. During a concurrent observation and interview on 5/6/2026 at 3:14 PM with TN 1 and TN 2 in Resident 85's room, Resident 85's treatment was being performed for the left fourth-finger stage 4 PU. There was no dressing in place on the wound. The left fourth-finger stage 4 PU was red and open. TN 2 stated there was no dressing in place on the wound before starting the treatment. TN 1 stated there is a physician's order to keep the wound covered with a dressing and this physician's order was not carried out. During a concurrent interview and record review on 5/7/2026 at 10:05 AM with TN 1, Resident 85's physician's order, dated 4/13/2026, was reviewed. The physician's order indicated Resident 85 may have a LALM for wound management and to check for the placement, function, and setting of the LALM every shift. TN 1 stated it the treatment nurse's responsibility to do rounds every morning to make sure the LALM is at the correct setting. If the LALM is left at the incorrect setting, it could lead to wound decline, delayed healing, or the development of a new PU. The order to monitor the LALM was not followed for Resident 85 because his LALM was at the incorrect setting. During an interview on 5/7/2026 at 10:06 AM with TN 1, TN 1 stated the physician's orders for two of Resident 85's PUs were not carried out. For Resident 85's right hip stage 3 PU and left fourth-finger stage 4 PU, the physician's orders were not carried out because the two wounds initially did not have dressings in place before starting their treatments. To follow the orders, the two wounds should be always covered with dressings. If these orders are not followed, Resident 85 is at risk for further skin breakdown and wound decline. During an interview on 5/7/2026 at 10:07 AM with TN 1, TN 1 stated that the care plans regarding Resident 85's LALM, right hip stage 3 PU, and left fourth-finger stage 4 PU were not carried out. The LALM was at the incorrect setting, and the two wounds did not have dressings. It is important to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	follow care plans because they guide nursing on what interventions to perform. During an interview on 5/7/2026 at 3:01 PM with the DON, the DON stated it is important to have LALMs be at the correct setting to ensure that they treat wounds and promote their healing or prevent new wounds from being formed. If the LALM is not at the appropriate setting, it could create a new wound or make the existing wound worsen. The DON further stated wounds with treatment orders to have dressings should have dressings in place to prevent infection. It is important to ensure care plans are followed because they tell nursing staff what they are supposed to and guide the care of the residents. During a review of the facility's LALM operator manual titled, Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System, undated, the manual indicated the LALM setting should be set at the patient's weight. During a review of the facility's policy and procedure (P&P) titled, Alternating Pressure Pad or Mattress, undated, the P&P indicated the facility may use specialized mattresses to prevent skin breakdown and to treat PUs of residents. During a review of the facility's policy and procedure (P&P) titled, Care Plan and Care Plan Update, undated, the P&P indicated the facility must ensure each resident receives the care and services to attain and maintain their highest practicable wellbeing. The care plan will be initiated upon identification of a resident need that requires intervention or monitoring. During a review of the facility's policy and procedure (P&P) titled, Skin Management System, undated, the P&P indicated a plan of care will be initiated to address areas of actual skin breakdown.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to promote healing for residents with pressure ulcer/injury (PU/PI, localized damage to the skin and/or underlying tissue usually over a bony prominence) and skin maintenance for five of seven sampled residents (Residents 1, 85, 3, 50 and 58) by failing to:a. Ensure Resident 1's Low Air Loss Mattress (LAL, a specialized medical support surface designed to prevent and treat skin ulcers by combining alternating pressure with a steady low-volume airflow) was set consistent with Resident 1's weight.b. Ensure Resident 85's LAL mattress pressure was set consistent with Resident 85's weight and treatment for Resident 85's PU was provided in accordance with physician's order.c. Ensure Resident 3's LAL mattress was set on alternating pressure (a system of interconnected air cells that inflate and deflate in cycles to continuously shift support and relieve pressure over bony prominence) and not on static.d. Ensure Resident 50's LAL mattress pressure was set consistent with Resident 50's weight.e. Ensure Resident 58's LAL mattress pressure was set consistent with Resident 58's weight. These failures had the potential to result in worsening of PU/PI or development of skin breakdown for Residents 1, 85, 3, 50 and 58. Findings: a. During a review of Resident 1's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 1 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnosis including but not limited to cerebral infarction (stroke, loss of blood flow to a part of the brain), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and cognitive communication deficit (communication difficulty caused by impaired thinking skills). During a review of Resident 1's progress note, dated 4/26/2026, the progress note indicated Resident 1 has the capacity to make needs known. During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 1/28/2026, the MDS indicated Resident 1 has moderate impairment of thinking and memory. The MDS indicated Resident 1 has one-sided impairment to upper and lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). The MDS also indicated Resident 1 is at risk for developing PUs. During a review of Resident 1's weight log, dated 5/7/2026, the weight log indicated Resident 1's most recent weight, taken on 4/5/2026, was 119 pounds. During an observation on 5/5/2026 at 9:33 AM in Resident 1's room, Resident 1 was lying in her bed asleep. Resident 1 had a LAL in place that was turned on. The setting on the LAL control panel was set to 210 pounds. During an interview on 5/5/2026 at 10:21 AM with Treatment Nurse (TN) 1, TN 1 stated Resident 1's LAL should not be set at 210 pounds. The LAL should be set to the resident's most recent weight. TN 1 stated the correct setting should be 119 pounds. During a concurrent interview and record review on 5/7/2026 at 10:00 AM with TN 1, Resident 1's physician's order, dated 4/13/2026, was reviewed. The physician's order indicated Resident 1 may have a LAL for wound management and to check for the placement, function, and setting of the LAL every shift. TN 1 stated it is the TN's responsibility to do rounds every morning to make sure the LAL is at the correct setting. If the LAL is left at the incorrect setting, it could lead to wound decline, (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delayed healing, or the development of a new PU. The order to monitor the LAL was not followed for Resident 1 because her LAL was at the incorrect setting. b. During a review of Resident 85's face sheet, dated 5/7/2026, the face sheet indicated Resident 85 was admitted to the facility on [DATE] with diagnoses including but not limited to malnutrition (a condition of imbalance between the nutrients the body needs to function and the nutrition it gets), dementia (a progressive state of decline in mental abilities), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 85's history and physical (H&P), dated 3/5/2026, the H&P indicated Resident 85 does not have the capacity to understand and make decisions. During a review of Resident 85's MDS, dated [DATE], the MDS indicated Resident 85 has severe problems with thinking or memory. The MDS indicated Resident 85 has one-sided impairment to upper and lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). The MDS also indicated Resident 85 is at risk for developing PUs and currently has PUs. During a review of Resident 85's weight log, dated 5/7/2026, the weight log indicated Resident 85's most recent weight, taken on 4/5/2026, was 102 pounds. During a review of Resident 85's physician's orders, dated 5/1/2026, the order indicated treatment instructions for Resident 85's right hip stage 3 PU (full-thickness loss of skin; dead and black tissue may be visible). The instructions were to cleanse the wound, pat dry, apply antiseptic (a substance applied to skin or tissue to destroy germs), then cover with a dressing every day and as needed for soiled or dislodged dressings. During a review of Resident 85's physician's orders, dated 4/29/2026, the order indicated treatment instructions for Resident 85's left fourth-finger stage 4 PU (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). The instructions were to cleanse the wound, apply ointment, then cover with a dressing every day and as needed for soiled or dislodged dressings. During an observation on 5/5/2026 at 9:26 AM in Resident 85's room, Resident 85 was lying in his bed asleep. Resident 85 had a LAL in place that was turned on. The setting on the LAL control panel was set to 200 pounds. During an interview on 5/5/2026 at 10:21 AM with TN 1, TN 1 stated Resident 85's LAL should not be set at 200 pounds. The LAL should be set to the resident's most recent weight. TN 1 stated the correct setting should be 102 pounds. During a concurrent observation and interview on 5/6/2026 at 3:11 PM with TN 1 and TN 2 in Resident 85's room, Resident 85's treatment was being performed for the right hip stage 3 PU. There was no dressing in place on the wound. The right hip stage 3 PU was red and had some scabs starting to form. TN 2 stated there was no dressing in place on the wound before starting the treatment. TN 1 stated there is a physician's order to keep the wound covered with a dressing and this physician's order was not carried out. During a concurrent observation and interview on 5/6/2026 at 3:14 PM with TN 1 and TN 2 in Resident 85's room, Resident 85's treatment was being performed for the left fourth-finger stage 4 PU. There was no dressing in place on the wound. The left fourth-finger stage 4 PU was red and open. TN 2 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated there was no dressing in place on the wound before starting the treatment. TN 1 stated there is a physician's order to keep the wound covered with a dressing and this physician's order was not carried out. During a concurrent interview and record review on 5/7/2026 at 10:05 AM with TN 1, Resident 85's physician's order, dated 4/13/2026, was reviewed. The physician's order indicated Resident 85 may have a LAL for wound management and to check for the placement, function, and setting of the LAL every shift. TN 1 stated it the treatment nurse's responsibility to do rounds every morning to make sure the LAL is at the correct setting. If the LAL is left at the incorrect setting, it could lead to wound decline, delayed healing, or the development of a new PU. The order to monitor the LAL was not followed for Resident 85 because his LAL was at the incorrect setting. During an interview on 5/7/2026 at 10:06 AM with TN 1, TN 1 stated the physician's orders for two of Resident 85's PUs were not carried out. For Resident 85's right hip stage 3 PU and left fourth-finger stage 4 PU, the physician's orders were not carried out because the two wounds initially did not have dressings in place before starting their treatments. To follow the orders, the two wounds should always be covered with dressings. If these orders are not followed, Resident 85 is at risk for further skin breakdown and wound decline. During an interview on 5/7/2026 at 3:01 PM with the Director of Nursing (DON), the DON stated it is important to have LALs be at the correct setting to ensure that they treat wounds and promote their healing or prevent new wounds from being formed. If the LAL is not at the appropriate setting, it could create a new wound or make the existing wound worsen. The DON further stated wounds with treatment orders to have dressings should have dressings in place to prevent infection. During a review of the facility's LAL operator manual titled, Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System, undated, the operator manual indicated the LAL setting should be set at the patient's weight. During a review of the facility's policy and procedure (P&P) titled, Alternating Pressure Pad or Mattress, undated, the P&P indicated the facility may use specialized mattresses to prevent skin breakdown and to treat PUs of residents. During a review of the facility's policy and procedure (P&P) titled, Skin Management System, undated, the P&P indicated it is the policy of the facility to ensure residents will have appropriate preventative measures taken to ensure residents do not develop PUs. The healthcare team will collaborate to support wound healing, pressure reduction, and prevention strategies. c. During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted Resident 3 on 1/7/2026 with diagnoses including stage 4 pressure ulcer (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) of the sacral region, stage 4 pressure ulcer of the right buttock, and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 4/10/2026, the MDS indicated Resident 3 had intact cognition (ability to understand and process information), The MDS indicated Resident 3 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and upper body dressing. The MDS indicated Resident 3 required (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	substantial/maximal assistance (helper did more than half the effort) with toileting, shower, lower body dressing and personal hygiene. During a review of Resident 3's Order Summary Report (OSR) dated 4/12/2026, the OSR indicated Resident 3 had an order to have LAL mattress for wound management and for staff to check placement, function, and setting every shift. During a review of Resident 3's Skin Issues (SI) dated 5/7/2026, the SI indicated Resident 3 had one or more unhealed pressure ulcers/injuries. During a concurrent observation inside Resident 3's room and interview on 5/5/2026 at 9:45 am with Certified Nurse Assistant 1 (CNA 1), Resident 3 was in bed sleeping. Resident 3 was using LAL mattress. CNA 1 stated the LAL mattress pressure was set at 120 and static. CNA 1 stated the number on the yellow sticker on the LAL pressure control unit was the most current weight of the resident. CNA 1 stated the resident's weight written on the yellow sticker was 159 pounds. d. During a review of Resident 50's AR, the AR indicated the facility initially admitted Resident 50 on 10/19/2018 and readmitted on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation of the legs), neuromuscular dysfunction of the bladder (occurs when brain, spinal cord, or nerve damage disrupts the signals required to store and empty urine), and presence of urogenital implants (surgically placed medical devices designed to restore or manage the function of the urinary and reproductive systems). During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 had intact cognition. The MDS indicated Resident 50 was dependent (helper did all the effort, resident did none) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a review of Resident 50's OSR dated 4/22/2026, the OSR indicated Resident 50 had an order to have LAL mattress for wound management and for staff to check placement, function, and setting every shift. During a concurrent observation inside Resident 50's room and interview on 5/5/2026 at 9:18 am with CNA 1, Resident 50 was in bed. Resident 50 was using LAL mattress. CNA 1 stated the LAL mattress pressure was set at 200. CNA 1 stated the number on the yellow sticker on the LAL pressure control unit was the most current weight of the resident. CNA 1 stated the resident's weight written on the yellow sticker was 168 pounds. During an interview on 5/7/2025 at 11:47 am with the Treatment Nurse (TN), the TN stated the LAL mattress was used for residents with pressure ulcer/injury and those at risk for developing or re-developing skin pressure ulcer/injury. The TN stated LAL mattress pressure should be set up according to the weight of the resident. The TN stated the LAL mattress should be set in static pressure (constant unchanging level of continuous air support that maintains the patient's body weight across the mattress surface) during care and back to alternating pressure after the care to relieve pressure on bony prominences and to help with healing and prevent developing new skin breakdowns. During an interview on 5/8/2026 at 8:59 am with the Director of Nursing (DON), the DON stated LAL mattress pressure should be set according to the resident's weight and on alternating pressure (not on static) to prevent worsening of existing pressure ulcers/injuries and prevent developing new skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	breakdowns. During a review of the facility's undated LAL Mattress Operation Manual (OM), the OM indicated, This digital control unit includes intuitive controls for adjusting the air pressure based on the patient's weight and comfort levels. Static button is available to discontinue alternation therapy for patient transfers, caregiving, comfort, and preference. During a review of the facility's undated Policy and Procedures (P&P) titled, Stage II, Stage III and Stage IV, the P&P indicated, Pressure relief devices as, as indicated, based on nursing & therapy assessments. e. During a review of Resident 58's AR, the AR indicated the facility initially admitted Resident 58 on 1/31/2022 and readmitted on [DATE] with diagnoses including type 2 diabetes mellitus (DM2, a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine) with foot ulcer (lesion/wound caused by unrelieved pressure that results in damage of underlying tissue) and morbid obesity (excessive body fats). During a review of Resident 58's MDS dated [DATE], the MDS indicated Resident 58 had intact cognition. The MDS indicated Resident 58 required maximum assistance (helper does more than half of the effort) from staff for toileting hygiene, lower body dressing, putting on/off footwear and personal hygiene. During a review of Resident 58's Monthly Weight and Vitals Summary (MWVS) dated 4/5/2026, the MWVS indicated Resident 58 weighed 283.4 pounds (lbs. unit of measurement). During a review of Resident 58's OSR dated 4/12/2026, the OSR indicated to use bariatric LAL mattress on Resident 58 for wound management. The OSR indicated for staff to check placement, function and setting every shift. During a review of Resident 58's untitled Care Plan (CP) revised on 4/17/2026, the CP indicated Resident 58 had a potential to develop pressure ulcer related to incontinence, bed bound, DM2 and obesity. The CP interventions indicated for nursing staff to place the LAL mattress, administer treatment as ordered and monitor for effectiveness. During an observation inside Resident 58's room and concurrent interview on 5/5/2026 at 9:27 am, with Licensed Vocational Nurse 4 (LVN 4), Resident 58 was awake and lying on LAL mattress. LVN 4 stated Resident 58's LAL setting was set at 400 lbs. During an interview and record review on 5/6/2026 at 1:57 pm with Treatment Nurse 1 (TN 1) of Resident 58's medical records (PointClickCare - PCC, a cloud-based software) was reviewed. TN 1 stated Resident 58 weighed 283.4 lbs. on 4/5/2026. TN 1 stated Resident 58 was on LAL due to history of bilateral pressure injury on the buttocks. TN 1 stated Resident 58's LAL mattress setting needed to be based on Resident 58's actual weight. TN 1 stated Resident 58 would be at risk of developing pressure ulcer if the LAL mattress was not set based on the resident's actual weight. During an interview on 5/6/2026 at 3:05 pm with the facility's Director of Nursing (DON), the DON (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, Resident 58's LAL mattress needed to be set up based on the resident's actual weight to prevent Resident 58 from developing pressure ulcer. During a review of the facility's undated user manual titled, Med-Aire Plus 10 Alternating Pressure and Low Air Loss Bariatric Mattress Replacement System, the manual indicated, Weight settings range from less than or equal to 250 to 1,000 lbs. and can be used to adjust the pressure of inflated cells based on the patients weight and comfort level.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents with indwelling catheter (including suprapubic catheter and nephrostomy tube, a flexible tube inserted into the body, usually the bladder through the urethra or through a small abdominal incision that remains in place for continuous, long-term urine drainage) for two of three sampled residents (Residents 50 and 104) by failing to:a. Ensure Resident 50's suprapubic catheter tubing was connected to a securement device on Resident 50's thigh.b. Ensure Resident 104's left and right nephrostomy catheter bags were positioned lower than the level of the bladder. These failures placed Residents 50 and 104 at risk for infection and injury related to the use of indwelling catheter. Findings: a. During a review of Resident 50's admission Record (AR), the AR indicated the facility initially admitted Resident 50 on 10/19/2018 and readmitted on [DATE] with diagnoses including paraplegia (loss of movement and/or sensation of the legs), neuromuscular dysfunction of the bladder (occurs when brain, spinal cord, or nerve damage disrupts the signals required to store and empty urine), and presence of urogenital implants (surgically placed medical devices designed to restore or manage the function of the urinary and reproductive systems). During a review of Resident 50's untitled Care Plan (CP) initiated on 9/27/2024, the CP indicated Resident 50 had a suprapubic catheter. The CP goal was for Resident 50 not to show signs and symptoms of infection. During a review of Resident 50's Minimum data Set (MDS, a resident assessment tool) dated 4/15/2026, the MDS indicated Resident 50 had intact cognition (ability to understand and process information). The MDS indicated Resident 50 was dependent (helper did all the effort) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 50's room and interview on 5/5/2026 at 9:18 am with Certified Nurse Assistant 1 (CNA 1), Resident 50 was in bed with suprapubic catheter bag hanging on the right side of the bed. The suprapubic catheter was half-way full of urine. CNA 1 stated the suprapubic catheter tubing was not attached to Resident 50's thigh with a securement device or strap. b. During a review of Resident's 104's AR, the AR indicated the facility admitted Resident 104 on 4/23/2026 with diagnoses including malignant neoplasm (cancerous tumor) of the colon, artificial openings of urinary tract, and colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body). During a review of Resident 104's MDS dated [DATE], the MDS indicated Resident 104 had intact cognition. The MDS indicated Resident 104 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral hygiene and substantial/maximal assistance (helper did more than half the effort) with toileting, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 104's room and interview on 5/5/2026 at 9:25 am with CNA 1, Resident 104 was in bed with left and right nephrostomy bags on top of the foot part of the bed. The foot/leg section of the bed was elevated. The left and right nephrostomy bags were placed higher than the level of Resident 104's bladder. CNA 1 stated both left and right nephrostomy bags were full. During an interview on 5/5/2026 at 9:31 am with the Treatment Nurse (TN), the TN stated the suprapubic catheter tubing should be connected to the resident's thigh to prevent pulling and dislodgement during bed mobility. The TN stated indwelling catheter bags should be placed lower than the level of the resident's bladder to prevent backflow of the urine and cause urinary tract infection (UTI, an infection in the bladder/urinary tract) to the resident. During an interview on 5/6/2026 at 3:05 pm with the Director of Nursing (DON), the DON stated indwelling catheter tubing should be attached to a securement device or strap on the resident's thigh to prevent pulling and cause trauma or injury to the resident. The DON stated indwelling catheter bags should be placed lower than the level of the resident's bladder and catheter bags should be emptied when (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	half-full, every shift and as needed to prevent backflow of the urine and cause infection to the resident. During a review of the facility's undated Policy and Procedure (P&P) titled, Catheter Care, Foley, the P&P indicated, Each resident with an indwelling catheter will receive catheter care daily and PRN (as needed) for soiling. To avoid tension of the catheter and in and out movement of the catheter, it will be secured with a catheter strap.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the integrity and proper labeling of peripherally inserted central catheter (PICC, a long, flexible tube inserted into a vein in the upper arm and guided into a large vein near the heart) line in accordance with professional standards of practice for two of five sampled residents (Resident 75 and Resident 106). These failures had the potential to result in infection and accidental PICC line dislodgement for Residents 75 and Resident 106.Findings: a. During a review of Resident 75's admission Record (AR), the AR indicated the facility admitted Resident 75 on 3/31/2026 with diagnoses including abscess of liver (a pus-filled mass that develops within the liver due to an infection or injury), bacteremia (the presence of bacteria in the blood stream), and diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 75's untitled Care Plan (CP) initiated on 4/2/2026, the CP indicated Resident 75 was at risk for infection related to presence of PICC line on the right upper arm. The CP interventions included changing the dressing per facility policy. The CP goal included monitoring Resident 75 for any signs and symptoms of pain or discomfort at the site. During a review of Resident 75's Order Summary Report (OSR) dated 4/2/2026, the OSR indicated Resident 75 had an order for licensed staff to monitor the right upper arm PICC line site for signs and symptoms of infection and complications. During a review of Resident 75's Minimum Data set (MDS, a resident assessment tool) dated 4/3/2026, the MDS indicated Resident 75 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 74 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and personal hygiene. The MDS indicated Resident 75 required partial/moderate assistance (helper did less than half the effort) with toileting and upper body dressing and substantial/maximal assistance (helper did more than half the effort) with shower and lower body dressing. The MDS indicated Resident 75 had an IV (within a vein) medication. During a concurrent observation inside Resident 75's room and interview on 5/5/2026 at 10:06 am with Licensed Vocational Nurse 1 (LVN 1), Resident 75 was sitting in a wheelchair with right upper arm PICC line. LVN 1 stated Resident 75's PICC line transparent dressing was loose and coming out. LVN 1 stated the PICC line dressing was not labeled with a date and LVN 1 did not know the last time the PICC line dressing was changed. LVN 1 stated the PICC line site should be maintained clean to prevent infection. b. During a review of Resident 106's AR, the AR indicated the facility admitted Resident 106 on 5/4/2026 with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract), extended spectrum beta lactamase (ESBL, refers to a type of enzyme produced by certain bacteria that makes them highly resistant to many common antibiotics) resistant, and DM. During a review of Resident 106's OSR dated 5/4/2026, the OSR indicated Resident 106 was on IV antibiotics therapy (use of specific medications to treat, manage, or prevent bacterial infections) for ESBL and UTI. During a review of Resident 106's untitled CP initiated on 5/5/2026, the CP indicated Resident 106 was at risk for infection related to presence of left upper arm PICC line site. The CP interventions included changing the dressings per facility policy and monitoring Resident 106 for any signs and symptoms of infection. During a concurrent observation inside Resident 106's room and interview on 5/5/2026 at 9:52 am with Registered Nurse 1 (RN 1), Resident 106 was in bed with a PICC line on Resident 106's left upper arm. Resident 106's PICC line had two (2) lumens. One of the lumens was not covered. RN 1 stated all PICC line lumens should be capped and covered when not in use for infection control. During an interview on 5/7/2026 at 10:47 am with RN 1, RN 1 stated PICC line dressing should be changed every seven (7) days and as needed to prevent getting contaminated and infected. During a review of Resident 106's MDS dated [DATE], the MDS indicated Resident 106 had intact cognition. The MDS indicated Resident 106 required partial/moderate assistance with oral hygiene and upper body dressing and substantial/maximal (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with toileting, shower and lower body dressing. The MDS indicated Resident 106 was dependent (helper did all the effort, resident did none) with personal hygiene. The MDS indicated Resident 106 was on IV antibiotic medications. During an interview on 5/8/2026 at 8:48 am with the Director of Nursing (DON), the DON stated PICC line site should be kept clean and the dressing changed every 7 days or as needed when dressing was loose and not clean to prevent infection and skin irritation. During a review of facility's undated Policy and Procedure (P&P) titled, Intravenous Site Crea, the P&P indicated, The facility will provide safe monitoring and care of intravenous and central lines sites in accordance with physician orders and infection prevention practices to reduce the risk of complications and infection. Dressing will be changed according to physician orders, facility protocol, and infection prevention guidelines. Tubing, caps, and supplies will be maintained and changed per facility protocol and/or manufacturer's recommendations.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents receiving respiratory therapy (a specialized healthcare field focused on assessing, treating, and managing patients with breathing or cardiopulmonary disorders) and oxygen therapy (a treatment that provides extra oxygen to breathe in) in accordance with professional standards of practice for two of four sampled residents (Residents 9 and 11) by failing to: a. Ensure Resident 9's nasal cannula (NC, a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) tubing was not touching the floor, the NC tubing was connected to the portable oxygen concentrator (POC, provides patients with a continuous or pulse-dose supply of supplemental oxygen) and the NC prongs (two small, curved tubes on a nasal cannula that rest directly inside the nostrils) were placed inside Resident 9's nostril. b. Ensure Resident 11's use of bilevel positive airway pressure (BIPAP, a non-invasive ventilator used to assist breathing) had a physician's order and the BIPAP mask was stored appropriately when not in use. These failures placed Residents 9 and 11 at risk for complications related to the use of oxygen, shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) and the risk of infection which could lead to respiratory complications.Findings: a. During a review of Resident 9's admission Record (AR), the AR indicated the facility initially admitted Resident 9 on 1/25/2021 and readmitted on [DATE] with diagnoses including epilepsy (recurrent, unprovoked seizures) and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 9's untitled Care Plan (CP) initiated on 8/12/2024, the CP indicated Resident 9 was on oxygen therapy related to COPD. The CP goal indicated Resident 9 would not have signs and symptoms of poor oxygen absorption. During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool) dated 3/2/2026, the MDS indicated Resident 9 had intact cognition (ability to understand and process information). The MDS indicated Resident 9 required set up or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating and oral hygiene. The MDS indicated Resident 9 required substantial/maximal assistance (helper did more than half the effort) with shower, lower body dressing and personal hygiene. The MDS indicated Resident 9 was on oxygen therapy. During a review of Resident 9's Order Summary Report (OSR) dated 4/12/2026, the OSR indicated Resident 9 had an order for oxygen at 2 liters (L)/minute (min) via nasal cannula every shift for COPD. During a concurrent observation inside Resident 9's room and interview on 5/5/2026 at 9:09 am with Licensed Vocational Nurse 1 (LVN 1), Resident 9 was in bed with NC. LVN 1 stated Resident 9's NC tubing was touching the floor, the NC tubing was not connected on the portable oxygen concentrator and the NC prongs were on Resident 9's left cheek. LVN 1 stated the NC tubing should not touch the floor to prevent contamination and infection. LVN 1 stated the NC tubing should be connected to the portable oxygen concentrator. LVN 1 stated the NC prongs needed to be placed inside Resident 9's nostrils to ensure Resident 9 received enough oxygen to prevent shortness of breath.b. During a review of Resident 11's AR, the AR indicated the facility admitted Resident 11 on 4/11/2026 with diagnoses including pneumonia (an infection/inflammation of the lungs), COPD, and morbid obesity (dangerous level of excess body fat). During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 had intact cognition. The MDS indicated Resident 11 required set up or clean-up assistance with eating and supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and personal hygiene. The MDS indicated Resident 11 required substantial/maximal assistance with toileting, shower, and lower body dressing. The MDS indicated Resident 11 was on oxygen therapy. During a concurrent observation inside Resident 11's room and interview on 5/5/2026 at 9:05 am with Certified Nurse Assistant 1 (CNA 1), Resident 11 was in bed. Resident 11's BIPAP mask was on top of the BIPAP machine. CNA 1 stated Resident 11 used the BIPAP machine during the night. During a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent interview and record review on 5/6/2026 at 9:56 am with Licensed Vocational Nurse 2 (LVN 2), Resident 11's Order Summary Report (OSR), with active orders as of 5/5/2026 were reviewed. LVN 1 stated Resident 11 did not have an order for the use of BIPAP machine at night. LVN 2 stated Resident 11 should have an order from the physician for the use of BIPAP machine to ensure Resident 11 had the correct setting and set up to manage Resident 11's health concerns. During an interview on 5/6/2026 at 3:11 pm with the Director of Nursing (DON), the DON stated staff should ensure all residents on oxygen therapy had the nasal cannula prongs placed properly in the resident's nostrils and connected to the portable oxygen concentrator to prevent oxygen desaturation (drop in blood oxygen levels below normal) and shortness of breath. The DON stated the NC tubing should not be touching the floor to prevent contamination and spread of infection. The DON stated the use of BIPAP required a doctor's order and prescription to ensure the setting was correct for the resident's condition. The DON stated BIPAP mask, nebulizer mask and nasal cannula should be stored inside the transparent bag intended for respiratory supplies when not in use to prevent infection. During a review of facility's undated Policy and Procedure (P&P) titled, Respiratory Supply, the P&P indicated, Respiratory supplies and equipment will be stored, maintained, and handled safely and in accordance with manufacturer's guidelines, infection prevention standards, CMS regulations, and California Title 22 requirements. During a review of facility's undated P&P titled, CPAP/BiPAP Support, the P&P indicated, Review the physician's order to determine the oxygen concentration and flow, and the PPE pressure for the machine. Set mode, CPAP, IPAP, and EPAP settings on the machine, as prescribed.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the actual nurse staffing information at the beginning of the shift in a prominent location, readily accessible to residents, visitors, and staff for viewing for one of four recertification survey days (5/5/2026). This failure had the potential to mislead the residents, visitors, and staff of the actual staffing in the facility that could affect the quality of nursing care provided to the residents. Findings: During an observation in the facility's lobby, hallways, reception area and North Nursing Station on 5/5/2026 at 12:50 pm, there was no daily nurse staffing information posted. During a concurrent observation in the South Nurse Station and interview on 5/5/2026 at 12:54 pm, with Infection Prevention Nurse (IPN), the IPN stated the IPN did not know where the staffing information was posted. The IPN stated there was no staffing information posted in North Nursing Station, lobby and in the facility's hallway. During a concurrent observation and interview on 5/5/2026 at 12:55 pm, with the Assistant Director of Staff and Development (ADSD), the ADSD stated the ADSD was responsible in posting the staffing information and the ADSD did not post the staffing information. During a concurrent interview with the Director of Nursing (DON) on 5/5/2026 at 1:52 pm, and record review of the facility's Policy and Procedure (P&P) titled Posting Direct Care Daily Staffing Numbers, the DON stated, the facility needed to post on a daily basis each shift, the nurse staffing data directly responsible for resident care and should be available in a prominent location accessible to residents and visitors. The DON stated staffing information should be easily seen and read by residents, staff, and visitors. The DON stated the nurse staffing information was inside a binder in the North Station. The DON stated the nurse staffing information was not readily accessible to staff, residents and visitors if it was inside a binder. During a concurrent observation in the South Nurse Station and interview on 5/5/2026 at 2:05 pm with the DON, the DON stated there was no staffing information posted in the South Nurse Station. The DON stated staff needed to bring the residents or visitors into the dining room if they wanted to see the staffing information. The DON stated the purpose of posting the staffing information was for the residents, visitors and staff to determine the facility had sufficient staff to take care of the residents. The DON stated the facility should post the staffing information in a prominent area where the residents, visitors and staff could access and view the form. During an interview on 5/7/2026 at 9:08 am with the facility's Administrator (ADM), the ADM stated the facility did not post the staffing information in the lobby or in the stations. The ADM stated the staffing information was placed inside a binder in the North Nurse Station. During an interview on 5/7/2026 at 11:10 am with Resident 23 inside Resident 23's room, Resident 23 stated it was far for Resident 23 to walk to the North Nurse Station to look for the staffing information and Resident 23 could not walk far. Resident 23 stated Resident 23 would like to view the staffing information posted in the South Nurse Station because the other station (North Nurse Station) was too far for Resident 23. During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted Resident 23 on 3/3/2026 with diagnoses including other symptoms and signs involving the musculoskeletal system and dysphagia (difficulty swallowing). During a review of Resident 23's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/9/2026, the MDS indicated Resident 23 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding). During a review of the facility's undated Policy and Procedure (P&P) titled, Posting Direct Care Daily Staffing Numbers, the P&P indicated the facility will post on a daily basis each shift the nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The number of licensed nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs and NAs) directly responsible for resident care should be available in a prominent location (accessible to residents and visitors) and in a clear and readable format. The charge nurse or designee completes the form and posts the staffing information in the location(s) designated by the administrator.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe food storage practices in one of one facility kitchen, by failing to: a. Discard a plate of chopped fresh fruit dated 4/28/2026 in the kitchen Refrigerator 1. b. Discard a plate of chopped fresh fruit dated 5/1/2026 in the kitchen Refrigerator 1. c. Discard an open loaf of white bread beyond its use-by-date (the last date the food was considered safe to eat) of 5/2/2026 in the kitchen bread storage area. d. Label two bags of frozen pie shells with the received date and expiration or discard date in the kitchen Freezer 1. e. Discard two unlabeled bags of frozen pie shells in the kitchen Freezer 1. These deficient practices had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) for the residents.Findings: a. During an observation with the presence of the Dietary Supervisor (DS) on 5/5/2026 at 8:24 AM of the kitchen Refrigerator 1, there was a plate of chopped fresh fruit dated 4/28/2026. b. During a concurrent observation and interview with the Dietary Supervisor (DS) on 5/5/2026 at 8:24 AM of the kitchen Refrigerator 1, there was a plate of chopped fresh fruit dated 5/1/2026. The DS stated the facility stored the chopped fresh fruit in the refrigerator for up to three days. The DS stated the kitchen staff should discard any chopped fresh fruit three days after the labeled date. The DS stated the fruit plate could have bacterial growth and placed the resident at risk of infection. The DS stated it was infection control to discard the fruit plate after three days of refrigeration to prevent the spread of bacteria and germs and avoid food-borne illness. c. During a concurrent observation and interview with the DS on 5/5/2026 at 8:39 AM in the kitchen bread storage area, there was one open loaf of white bread beyond its use-by-date of 5/2/2026. The DS stated the kitchen staff should discard the bread because it was beyond the use-by-date of 5/2/2026 and should not be kept in the kitchen. The DS stated that the bread that was beyond the use-by-date had the potential to cause infection/ food-borne illness. The DS stated the DS should discard any food items beyond the use-by-date during daily checking in kitchen. d. and e. During a concurrent observation and interview with the DS on 5/5/2026 at 8:47 AM in kitchen Freezer 1, there were two undated bags of frozen pie shells. The DS stated the DS did not see any dates labeled on the two bags of frozen pie shells. The DS stated the kitchen staff should label the two bags of frozen pie shells with received and opened dates. The DS stated labelling food with dates helped track when it was received and opened, ensure proper freezer storage and support infection control. During an interview with the Director of Nursing (DON) on 5/8/2026 at 8:41 AM, the DON stated food beyond the used-by date should not be stored in the facility kitchen because the food should not be consumed to prevent infection and food-borne illness. During a review of the facility's undated Policy and Procedure (P&P) titled, Food Labeling, the P&P indicated the facility would properly label all food items stored, prepared, or served to promote food safety, prevent contamination, and support resident health. The P&P indicated the facility should label all refrigerated and stored food items with the received date and expiration or discard date. The P&P indicated the facility should discard expired, unlabeled, or improperly labeled food items. The P&P further indicated that food labeling practices would follow safe food handling and infection prevention standards.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the dumpster area free from litter and securely cover four of four large facility trash bins, as indicated in the facility's Policy and Procedure (P&P) on garbage and rubbish disposal. These deficient practices had the potential to attract vermin (animals that are harmful and carry diseases) and pests (any living thing that has a negative effect on humans) that could potentially enter the facility, affect the resident care areas, and expose the residents and staff to diseases. Findings: During a review of Resident 23's admission Record (AR), the AR indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including anxiety disorder (mental health condition with persistent, excessive, and uncontrollable fear or worry that interferes with daily functioning), and major depressive disorder (a mental disorder with persistent, severe low mood, sadness, or a loss of interest in activities). During a review of Resident 23's History and Physical (H&P) dated 3/5/26, the H&P indicated Resident 23 had the capacity to understand and make decisions. During a facility tour on 5/5/2026 at 1:00 PM, one of four large trash bins had open lid and there was trash on the floor surrounding the trash bin area. During an observation and interview inside Resident 23's room on 5/6/2026 at 9:59 AM, there was one dead cockroach on top of Resident 23's bathroom door. Resident 23 stated, I don't like them. I don't like bugs. During an interview with Certified Nursing Assistant 3 (CNA3) on 5/6/2026 at 10:01 AM, CNA 3 stated there was a dead cockroach on the top part of Resident 23's door. CNA 3 stated there should not have bugs or cockroaches inside a resident's room because it was not sanitary and an infection control issue. During an interview with the Housekeeper (HKP) on 5/6/2026 at 10:03 AM, the HKP stated bugs could get in through the bottom of the door since there was no weather strip (seals gaps around movable building components like doors and windows) to block them from getting in. The HKP stated bugs should not be inside the facility because it was not sanitary. During an observation of the facility's driveway and parking lot area on 5/7/2026 at 7:38 AM, there was one used/dirty blue face mask and used/dirty white gloves on the ground, outside the entrance area. During the same observation, another pair of dirty blue gloves was observed on the ground outside the facility's entrance driveway. Also, there was an empty blue bag of chips and an empty cup container that had been discarded on the ground of the parking lot area. During an interview with the Maintenance Supervisor (MS) on 5/7/2026 at 8:07 AM, the MS stated MS was responsible for maintaining the facility clean, safe and sanitary. The MS stated the MS was made aware of a bug that was inside of one of the residents' rooms. The MS stated, I think it was from the rain. I was not sure how it got in. It's not ok to have bugs/cockroaches inside the residents' rooms because it was an infection control issue and could make the residents sick. During a concurrent tour of the facility's parking lot area with the MS on 5/7/2026 at 8:11 AM, four large trash dumpsters located outside the kitchen area in the parking lot were overfilled with bags of trash preventing the lids from closing. The MS stated the trash dumpster lids should be closed and the bins should not be overfilled with bags of trash. The MS stated it was unacceptable to have overfilled trash bins and trash on the floor/ground in the surrounding areas of the facility even if it was in the parking lot area. The MS stated this was an infection control issue since this could bring rodents or bugs to the facility. During an interview with the Infection Control Nurse (IPN) on 5/8/2026 at 7:39 AM, the IPN stated it was not acceptable to have the trash dumpsters overfilled with trash bags. The IPN also stated the trash dumpster's lids needed to be completely closed to prevent trash falling over onto the ground. The IPN stated if there was trash on the ground or the trash dumpsters lids were not securely closed, it could attract rodents or bugs. During a review of the facility's undated P&P titled Garbage and Rubbish Disposal, the P&P indicated, It is the policy of the facility that garbage and rubbish shall be disposed of in accordance with current state laws regulating such matters. Outside dumpsters provided by garbage pickup services must be kept closed and free of litter around the dumpster area. During a review of the (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's undated P&P titled Maintenance Department, the P&P indicated it is the policy of the facility to maintain a clean and safe facility and grounds. During a review of the facility's undated P&P titled Physical Environment, the P&P indicated, It is the policy of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public through monthly environmental rounds. During a review of the facility's undated P&P titled Homelike Environment, the P&P indicated to provide a homelike environment for the residents. During a review of the facility's undated P&P titled Housekeeping, the P&P indicated the facility will maintain a clean, safe, sanitary, and comfortable environment.

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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 promote and treat one of one sampled resident (Resident 5) with respect, privacy and dignity in accordance with facility's policy titled Dignity and Respect. This deficient practice had the potential to cause psychosocial (mental and emotional well-being) decline and low self-esteem for Resident 5.Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 3/21/2026 and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (GT, tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) status. During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/26/2026, the MDS indicated, Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 needed maximum assistance (helper does more than half the effort) from staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 5/5/2026 at 8:52 am with Licensed Vocational Nurse 2 (LVN 2) inside Resident 5's room, Resident 5 was awake, lying in bed. LVN 2 pulled up Resident 5's gown and assessed Resident 5's GT site. LVN 2 did not close the privacy curtain of Resident 5 to provide Resident 5's privacy, exposing Resident 5's abdominal area to the roommate and passerby. LVN 2 stated, LVN 2 did not close the privacy curtain and Resident 5's door prior to assessing Resident 5's GT site. LVN 2 stated, privacy curtain and room door needed to be closed prior to providing care and treatment to Resident 5 to provide privacy. During an interview on 5/6/2026 at 3:02 pm with the facility's Director of Nursing (DON), the DON stated the resident's privacy curtain and room door needed to be closed prior to providing care and treatment to Resident 5 to provide privacy, dignity and comfort. During a review of the facility's undated Policy and Procedure (P&P) titled, Dignity and Respect,, the P&P indicated It is the policy of the facility that all residents be treated with kindness, dignity and respect. Residents shall be treated in a manner that maintains the privacy of their bodies. A closed door or drawn curtain shields the Resident from passers-by. Privacy of a Resident's body shall be maintained during toileting, bathing and other activities of personal hygiene, except when staff assistance is needed for the resident's safety.

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Mesa Glen Care Center	638 E Colorado Avenue Glendora, CA 91740

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's bathroom sink was repaired for one of four sampled residents (Resident 23) when Resident 23's bathroom sink did not produce freely flowing hot water.This failure had the potential to increase Resident 23's risk of physical and emotional discomfort and distress due to a lack of access to hot water. Findings: During a review of Resident 23's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including but not limited to cervical disc disorder (the breakdown of the cushion-like pads separating the bones in the neck), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition that causes intense and constant feelings of worry and fear). During a review of Resident 23's History and Physical (H&P), dated 3/5/2026, the H&P indicated Resident 23 has the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 23 has no impairment to upper or lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). The MDS also indicated Resident 23 requires partial assistance with toileting hygiene and personal hygiene. During an interview on 5/5/2026 at 9:06 AM with Resident 23, Resident 23 stated the sink in her bathroom never works properly. She stated she can get cold water easily, but the hot water does not run. When she turns on the hot-water faucet handle, water barely trickles out and the water never gets hot. She has told staff before, but it has never been fixed. She further stated she wishes the hot water worked in her sink because it is more comfortable when washing hands.During an observation on 5/5/2026 at 9:10 AM in Resident 23's bathroom, the cold-water faucet handle was turned on. Water flowed freely from the sink and the water was cold. Then the hot-water faucet handle was turned on. Water slowly trickled out of the sink in drops and at a significantly slower rate than when the cold-water faucet handle was turned on. The temperature of the water was also cold. The hot-water faucet handle was left on to allow time to observe the temperature of the water. During an observation on 5/5/2026 at 9:15 AM in Resident 23's bathroom, the hot-water faucet handle was still turned on, and water was slowly trickling out of the sink. The temperature of the water coming out of the sink was still cold after being let run for five minutes continuously. During a concurrent observation and interview on 5/6/2026 at 10:38 AM with the Maintenance Supervisor (MS) in Resident 23's bathroom, the function of the bathroom sink was tested. When the cold-water faucet handle was turned on, water flowed freely and the temperature of the water was cold. When the hot-water faucet handle was turned on, water slowly trickled out and the temperature of the water was cold. MS stated the water from the sink is not getting warm. Hot water should flow freely from the sink when the hot-water faucet handle is turned on and the temperature should immediately start warming up. MS stated the sink is not working as it should, and it is important that the residents have access to hot water in their bathroom sinks to honor their preferences. During an interview on 5/7/2026 at 3:02 PM with the Director of Nursing (DON), the DON stated it is important for residents to have working bathroom sinks because it ensures their environment is homelike. Equipment should not be broken, and they should have access to running hot water in their bathrooms. During a review of the facility's policy and procedure (P&P) titled, Physical Environment, undated, the P&P indicated the facility must provide a functional and comfortable environment for residents. Resident rooms must be equipped for the comfort of residents.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 46) was free from restraints. Resident 46 had a Wanderguard (a wearable security device used to manage and monitor residents prone to wandering or at risk of leaving the facility) without a physician's order. This failure placed Resident 46 at risk for psychological distress (an experience of emotional, mental, suffering that occurs when individuals are overwhelmed) related to the use of the Wanderguard alarm.Findings: During a review of Resident 46's admission Record (AR), the AR indicated Resident 46 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a type of stroke that happens when blood, which carries oxygen, gets blocked from reaching a part of the brain), schizophrenia (mental illness) and dementia (a decline in mental ability severe enough to interfere with daily life). During a review of Resident 46's Minimum Data Sheet (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 46 had moderately impaired cognition (ability to understand) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and personal hygiene and upper body dressing and partial/moderate assistance (helper did less than half the effort) with toileting, shower, lower body dressing and putting on/taking off footwear. During a review of Resident 46's Assessment Outcomes (AO-elopement evaluation) dated [DATE], the AO indicated Resident 46 was at risk for elopement. During a review of Resident 46's untitled Care Plan Report (CPR) with a revision date of [DATE], the CPR indicated Resident 46 had Wanderguard in place due to Resident 46's risk for wandering/elopement. During a review of Resident 46's Resident Informed Consent Physical Restraint or Medical Device (ICPR or MD) dated [DATE], the ICPR or MD indicated an informed consent from Resident 46's responsible party (RP) was obtained via phone for Resident 46's use of a Wanderguard During a review of Resident 46's Order Summary Report (OSR), the OSR indicated an active order for staff to check Wanderguard placement on Resident 46's left wrist functionality every shift, ordered on [DATE]. The OSR also indicated Resident 46 had an active order for staff to monitor Resident 46's skin integrity to the left wrist with wander guard for signs and symptoms of skin breakdown, ordered on [DATE]. The OSR did not indicate an order and reason for the use of Wanderguard for Resident 46. During an observation on [DATE] at 11:38 AM, at the South Nursing Station, Resident 46 was observed ambulating in the hallway near the nursing station with Wanderguard alarm bracelet on the right wrist. During an observation and interview inside Resident 46's room with Certified Nursing Assistant 3 (CNA3) on [DATE] at 12:50 PM, Resident 46 was resting in bed. CNA3 stated Resident 46 had a Wanderguard applied to the right wrist. CNA3 stated CNA3 checked Resident 46's skin every day to ensure Resident 46 had no cuts, rashes or bruises from the Wanderguard. During an interview and record review with License Vocational Nurse 3 (LVN 3) on [DATE] at 12:56 PM, LVN 3 stated based on the active/current orders for Resident 46, there was no physician's order for the use of a Wanderguard. LVN 3 stated while reviewing the discontinued orders, Wanderguard for Resident 46 was discontinued since [DATE]. LVN3 stated Resident 46 should not be wearing a Wanderguard if there was no active physician's order. LVN 3 stated a physician's order was needed since the Wanderguard was a restraint. During a concurrent observation and interview with LVN 3 inside Resident 46's room on [DATE] at 1:00 PM, Resident 46 was resting in bed. LVN 3 stated Resident 46 was wearing a Wanderguard on the right wrist. LVN 3 stated staff were monitoring for the Wanderguard placement but there was no actual physician's order for Resident 46 to use a Wanderguard. LVN 3 stated it was important to have a physician's order for a Wanderguard because it was considered a restraint device and Resident 46's Responsible Party (RP) needed to sign the consent for Resident 46 to have a Wanderguard. During an interview and record review with (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Treatment Nurse 2 (TN2) on [DATE] at 1:55 PM, TN 2 stated the Wanderguard was considered a type of restraint because it restricted the resident from going out and prevented the resident from leaving the facility. TN 2 stated there was an order for Wanderguard monitoring, placement assessment and skin check but there was no actual physician's order for the Wanderguard to be placed on Resident 46. TN 2 stated it was not acceptable to place a Wanderguard on Resident 46 without a physician's order. During an interview with the Infection Prevention Nurse (IPN) on [DATE] at 7:49 AM, the IPN stated the Wanderguard was a security system device to alert staff when a resident who was at risk of elopement tried to leave the building. IPN stated that in order to use a Wanderguard, a physician's order was needed. IPN stated, in order for a resident to have a Wanderguard, an elopement assessment should be completed, a consent must be signed, and a physician's order needed to be in place. During an interview with the Director of Nursing (DON) on [DATE] at 8:32 AM, the DON stated the Wanderguard was used on a resident when the resident was at risk for elopement. The DON stated the purpose of a Wanderguard was to alert the staff if a resident attempted to exit the facility. The DON stated the Wanderguard was considered a restraint and should have a physician's order and consent before it could be placed on Resident 46. During a review of the facility's Policy & Procedure (P&P) titled, Use of Restraints, revised [DATE], the P&P indicated, Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it.that device is considered a restraint. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). During a review of the facility's undated P&P titled Devices, the P&P indicated, The facility will utilize monitoring devices (e.g. wander guard, alarm, etc.) for residents assessed at risk, to promote safety.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to revise the care plan for one of three sampled residents (Resident 64) when her care plan indicated to provide her with two conflicting diets (meals that meet daily and special dietary needs of each resident).This failure had the potential to result in Resident 64 not receiving the appropriate diet, leading to malnutrition (a condition where the body does not get the right balance of nutrients to function correctly). Findings: During a review of Resident 64's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 64 was admitted to the facility on [DATE] with diagnoses including but not limited to type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), cerebral infarction (stroke, loss of blood flow to a part of the brain), and hypertensive chronic kidney disease (a condition where long-term high blood pressure damages the blood vessels of the kidneys). During a review of Resident 64's History and Physical (H&P), dated 8/14/2025, the H&P indicated Resident 64 has the capacity to make her needs known. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 64 is capable of normal cognition and memory. During a concurrent interview and record review on 5/6/2026 at 2:50 PM with the Director of Nursing (DON), Resident 64's nutrition assessment, dated 10/29/2025, was reviewed. The nutritional assessment indicated Resident 64's diet order was a fortified diet (a diet that adds extra vitamins and minerals to boost their nutritional value). The DON stated Resident's 64's prescribed diet is a fortified diet.During a concurrent interview and record review on 5/7/2026 at 9:31 AM with the Minimum Data Set Coordinator (MDSC), Resident 64's physician's order, dated 10/9/2026, was reviewed. The order indicated Resident 64 should have a fortified diet with regular texture. MDSC stated that is the only active diet order for Resident 64. During a concurrent interview and record review on 5/7/2026 at 9:32 AM with the MDSC, Resident 64's care plans were reviewed. The care plan titled, The Resident has Potential Nutritional Problem Related to Fortified Diet., last revised on 12/11/2025, indicated to serve the fortified diet as ordered. The care plan titled, Resident is at Risk of Altered Nutrition/Hydration., last revised on 8/28/2024, indicated Resident 64 is on a Consistent Controlled Carbohydrate (CCHO - a diet that manages blood sugar by eating a balanced amount of carbohydrates at the same time each day) No Added Salt (NAS - a diet that limits salt intake by excluding added salt in food) diet and to serve the diet as ordered. MDSC stated the care plans are confusing because there are two different care plans with two different diet orders. MDSC stated the care plan should be revised to identify the correct diet. It is important for care plans to be revised so they may clearly guide staff on how to care for the residents. During an interview on 5/7/2026 at 3:01 PM with the DON, the DON stated it is important to keep care plans up to date because they guide how the residents should be cared for. Updated care plans show nursing staff what interventions they should do. During a review of the facility's policy and procedure (P&P) titled, Care Plan and Care Plan Update, undated, the P&P indicated care plans must be reviewed and revised with significant changes in condition and as needed based on resident progress or decline. Care plans may be resolved or discontinued when the intervention is no longer applicable.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview, and record review, the facility failed to ensure non-English speaking (refers to individuals who cannot speak or understand or have difficulty speaking or understanding the English language) residents were provided with a communication device in a language that the resident understood for one of one sampled resident (Resident 105). This failure had the potential to affect Resident 105's communication with staff and had the potential for delay in the provision of care, treatment and service to the resident.Findings: During a review of Resident 105's admission Record (AR), the AR indicated the facility admitted Resident 105 on 5/1/2026 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), and anxiety (a feeling of fear, dread, or unease). During a concurrent observation inside Resident 105's room and interview on 5/5/2026 at 9:47 am with Licensed Vocational Nurse 1 (LVN 1), Resident 105 was in bed. Resident 105 smiled when greeted and did not answer when asked. LVN 1 stated Resident 105 did not speak or understand English. LVN 1 stated Resident 105 did not have a communication board in the room. LVN 1 stated all residents in which English was not the residents' primary language (language an individual uses most frequently and proficient) should have a communication board with pictures and descriptions of their spoken language in the room for the resident to communicate basic needs and for the staff to understand the residents better and ensure the needs of the residents were met. During a review of Resident 105's Minimum Data Set (MDS, a resident assessment tool) dated 5/8/2026, the MDS indicated Resident 105's preferred language was Korean. The MDS indicated Resident 105 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 105 required set up or clean-up assistance (helper sets up or cleans up; resident completes the activity) with eating and oral hygiene. The MDS indicated Resident 105 required supervision or touching assistance (helper provided verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting, shower, upper/lower body dressing and personal hygiene. During an interview on 5/8/2026 at 9:11 am with the Director of Nursing (DON), the DON stated all non-verbal, but alert and oriented residents and non-English speaking residents should have a communication board in the room to express their needs and staff be able to address the resident's needs appropriately. During a review of the facility's undated Policy and Procedures (P&P) titled, Communication Board, the P&P indicated, The facility will make reasonable effort to communicate effectively with residents who do not speak or understand English. The facility may utilize: Communication board, Translation services, Picture boards, and interpreter assistance.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 64) was provided with bilateral quarter side rails on her bed for mobility and repositioning as ordered.This failure had the potential to cause a decline in Resident 64's mobility and independence.Findings: During a review of Resident 64's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 64 was admitted to the facility on [DATE] with diagnoses including but not limited to type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), cerebral infarction (stroke, loss of blood flow to a part of the brain), and hypertensive chronic kidney disease (a condition where long-term high blood pressure damages the blood vessels of the kidneys). During a review of Resident 64's History and Physical (H&P), dated 8/14/2025, the H&P indicated Resident 64 has the capacity to make her needs known. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 64 is capable of normal cognition and memory. The MDS also indicated Resident 64 has no impairment to the upper extremities (shoulder, elbow, wrist, hand) and one-sided impairment to the lower extremities (hip, knee, ankle, foot). The MDS indicated Resident 64 requires moderate assistance with rolling from left to right side when lying in bed. During a review of Resident 64's care plan titled, The Resident Uses Quarter Side Rails for Mobility and Repositioning, created on 11/4/2024, the care plan indicated Resident 64 should remain free of complications, including contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion). The care plan also indicated to monitor for decreases in Resident 64's self-performance of activities of daily living. During a concurrent observation and interview on 5/5/2026 at 11:48 AM with Resident 64 in Resident 64's room, Resident 64 was lying in her bed that was not equipped with side rails. Resident 64 stated she is upset the facility removed the side rails from her bed. She stated previously when she did have side rails, she would use her right arm to grab onto the side rails so she could turn her body from side to side. She further stated because her side rails have been gone for weeks, she has not been able to turn herself. She does not know why they removed them. During a concurrent interview and record review on 5/7/2026 at 10:20 AM with Licensed Vocational Nurse (LVN) 3, Resident 64's physician's order, dated 11/4/2024, was reviewed. The physician's order indicated Resident 64 may have bilateral quarter side rails on her bed to assist with mobility and repositioning. LVN 3 stated Resident 64 does not currently have side rails attached to her bed, and this order is not currently followed. LVN 3 further stated it is important for Resident 64 to have the bed side rails placed as ordered to help with her mobility so she can turn herself from side to side. During an interview on 5/7/2026 at 3:01 PM with the Director of Nursing (DON), the DON stated it is important for the facility to provide residents with the equipment they need to prevent a decrease in their ROM or mobility. During a review of the facility's policy and procedure (P&P) titled, Restorative Care, undated, the P&P indicated the resident will receive the services needed to attain and maintain the highest possible physical functional status.

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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 interview and record review, the facility failed to address the significant weight loss (the resident lost a large amount of weight in a short time) for one of five sampled residents (Resident 65) who had significant weight loss of 6.52 percentage (%) from 3/20/2026 to 3/29/2026. This deficient practice placed Resident 65 at risk for further weight loss. Findings: During a review of Resident 65's admission Record (AR), the AR indicated the facility admitted Resident 65 on 1/12/2026 and readmitted on [DATE] with diagnoses including acute respiratory failure with hypoxia (the resident suddenly had trouble breathing and did not get enough oxygen) and major depressive disorder (a mood disorder that caused a persistent feeling of sadness and loss of interest). During a review of Resident 65's History and Physical (H&P) dated 3/26/2026, the H&P indicated Resident 65 did not have the capacity to understand and make decisions. During a review of Resident 65's Minimum Data Set (MDS, a resident assessment tool) dated 4/23/2026, the MDS indicated Resident 65 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 65 required setup assistance from staff with eating. The MDS indicated Resident 65 required moderate assistance (helper did less than half the effort) from staff with oral hygiene. The MDS indicated Resident 65 required maximal assistance (helper did more than half the effort) from staff with toileting hygiene, showering/ bathing, and personal hygiene. The MDS indicated Resident 65 was dependent (helper did all the effort) on staff for bed-to-chair transferring. During a review of Resident 65's Weights and Vitals Exceptions (WVE), the WVE indicated Resident 65 weighed 89.2 pounds (lbs.) on 3/5/2026. The WVE indicated Resident 65 weighed 98.2 lbs. on 3/20/2026 (re admission weight). The WVE indicated Resident 65 weighed 91.8 lbs. on 3/29/2026. The WVE indicated that Resident 65 had weight loss of 6.5% from 3/20/2026 to 3/29/2026. The WVE indicated Resident 65 weighed 91 lbs. as of 5/7/2026. During an interview with Registered Nurse 1 (RN 1) on 5/7/2026 at 10:24 AM, RN 1 stated the facility should have addressed Resident 65's 6.52 % weight loss in 3/2026 because it was the professional standard of care. RN 1 stated the licensed nurse should document Resident 65's weight loss in the nurses' progress note (NPP). RN 1 stated the licensed nurse should notify the physician and responsible party, follow up with registered dietitian's recommendation, notify the Director of Nursing (DON) and wound care team, develop care plan, and complete a change of condition assessment. During a concurrent record review and interview with RN 1 on 5/7/2026 at 10:24 AM, Resident 65's entire medical record was reviewed. There was no documentation indicated the facility addressed Resident 65's 6.52 % weight loss in 3/2026. RN 1 stated there was no documentation in Resident 65's NPP indicating the facility notified Resident 65's physician or responsible party regarding the weight loss. RN 1 stated there was no change of condition (COC) assessment, interdisciplinary team (IDT, a team of different staff who worked together to plan and review the resident's care) conference record and care plan initiated to address Resident 65's weight loss. During a concurrent record review and interview with Licensed Vocational Nurse 4 (LVN 4) on 5/7/2026 at 10:43 AM, Resident 65's entire MDS assessments were reviewed. There was no MDS assessment indicating Resident 65's 6.52 % weight loss. During an interview with the Dietary Supervisor (DS) on 5/8/2026 at 8:21 AM, the DS stated Resident 65 was in-and-out of the hospital and the resident's weight was fluctuating, making it hard to maintain a stable weight. The DS stated the facility should have addressed Resident 65's weight loss in 3/2026 to prevent further weight loss. During an interview with the DON on 5/8/2026 at 8:41 AM, the DON stated it was a significant weight loss when Resident 65's weights changed from 98.2 lbs. on 3/20/2026 to 89 lbs. on 3/29/2026. The DON stated the licensed nurse should have completed the COC assessment and MDS significant change assessment, notified the physician and registered dietitian, and developed a weight loss care plan. The DON stated it was important to address Resident 65's significant weight loss to develop interventions to find out the root cause. The DON stated the restorative nurse assistant (RNA) should (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have notified the licensed nurse when there were weight changes on the residents. The DON stated it was the facility's standard of practice to notify the licensed nurse of weight changes. The DON stated Resident 65 was at risk of further weight loss, malnutrition, and wounds, when the facility did not address Resident 65's significant weight loss on 3/29/2026. During a review of the facility's Policy and Procedure (P&P) titled, Weight Assessment and Intervention, undated, the P&P indicated the facility should monitor the resident with undesirable or unintended weight loss. The P&P indicated the facility should evaluate resident with undesirable weight change, including:a. The resident's calorie, protein, and other nutrient needs compared with the resident's current intake;b. The relationship between current medical condition or clinical situation and recent fluctuations in weight; andc. Whether and to what extent weight stabilization or improvement could be anticipated.The P&P indicated the physician and the IDT should identify conditions and medications that might be causing the weight loss or increasing the risk of weight loss. The P&P further indicated the facility should have individualized care plans to address the identified causes of weight loss with goals and benchmarks for improvement.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview, and record review, the facility failed to provide residents on hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) an emergency kit (E-kit, contains the main items needed in an emergency) at the bedside for one of one sampled resident (Resident 2). This failure had the potential for Resident 2 not to receive emergency treatment from complications caused by unexpected bleeding from the hemodialysis access site. Findings: During a review of Resident 2's admission Record (AR), the AR indicated the facility admitted Resident 2 on 3/3/2026 with diagnoses including end stage renal disease (ESRD, irreversible kidney failure) and dependence on renal dialysis (treatment for kidney failure that removes unwanted toxins, waste products and excess fluids by filtering the blood). During a review of Resident 2's Minimum Data Set (MDS, a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 2 had moderately impaired cognition (ability to understand and process interventions). The MDS indicated Resident 2 was dependent (helper does all of the effort) from staff with toileting, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 2 required maximum assistance (helper did more than half the effort) from staff with shower and upper body dressing. During a review of Resident 2's Order Summary Report (OSR) dated 5/4/2026, the OSR indicated for staff to check the dialysis site for bleeding and signs/symptoms of infection. The OSR indicated if bleeding occurred, apply pressure dressing. During a concurrent observation and interview on 5/5/2026 at 9:12 am with Licensed Vocational Nurse 4 (LVN 4) inside Resident 2's room, Resident 2 was awake, lying in bed with hemodialysis access site on the left chest. LVN 4 stated Resident 2 did not have an E-kit at bedside. LVN 4 stated Resident 2 needed to have an E-kit at bedside, accessible and visible for staff to use in case of bleeding from the dialysis access site. During an interview on 5/6/2026 at 2:54 pm with the Director of Nursing (DON), the DON stated residents who were on hemodialysis needed to have an E-kit at bedside, visible, close and easily accessible to staff to use to stop and control if bleeding occurred from the hemodialysis access site. During a review of the facility's undated Policy and Procedure (P&P) titled, Hemodialysis Access Care, the P&P indicated, If there is bleeding from site (post-dialysis), apply gauze and pressure dressing and notify the physician.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to implement its Policy and Procedure (P&P) on the use of bed rails/siderails (adjustable metal or rigid plastic bars attached to the bed) for one of one sampled resident (Resident 106). This failure placed Resident 106 at risk of entrapment and injury from the use of bed rails.Findings: During a review of Resident 106's admission Record (AR), the AR indicated the facility admitted Resident 106 on 5/4/2026 with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), depression (a mood disorder that causes a persistent feeling of sadness, emptiness, and a loss of interest in activities), and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 106's Minimum Data Set (MDS- a resident assessment tool) dated 5/8/2026, the MDS indicated Resident 106 had intact cognition (ability to understand and process information). The MDS indicated Resident 106 required partial/moderate assistance (helper did less than half the effort) with oral hygiene and upper body dressing and substantial/maximal assistance (helper did more than half the effort) with toileting, shower and lower body dressing). The MDS indicated Resident 106 was dependent (helper did all the effort, resident did none) with personal hygiene. During an observation inside Resident 106's room on 5/5/2026 at 9:59 am, Resident 106 was in bed with one-half (1/2) bedrail up on both sides of the bed. Resident 106 stated Resident 106 needed help with bed mobility. Resident 106 had bilateral (both sides) above the knee amputation (AKA, surgical removal of the portion of the leg above the knee). During a concurrent interview and record review on 5/6/2026 at 10:20 am with Licensed Vocational Nurse 2 (LVN 2), Resident 106's medical record (chart) and Order Summary Report, with active orders as of 5/5/2026 were reviewed. LVN 2 stated Resident 106 did not have a physician's order and informed consent from Resident 106 or Resident 106's representative before the installation of bilateral half side rails. LVN 2 stated a physician's order and informed consent should have been obtained before the installation of bilateral side rails for Resident 106 to ensure the resident and/or the resident's representative were educated and understood the risks and benefits of using the side rails for the safety of the resident and to prevent injury and entrapment. During an interview on 5/6/2026 at 3:05 pm with the Director of Nursing (DON), the DON stated a physician's order and an informed consent should have been obtained prior to the installation of siderails to ensure the use of siderails was appropriate for Resident 106 and the risks and benefits were explained and understood, for Resident 106's safety. During a review of the facility's undated P&P titled, Bed Safety and Bed Rails, the P&P indicated, Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtained informed consent. The following information will be included but is not limited to: The assessed medical needs that will be addressed with the use of bed rails; The resident's risks from the use of bed rails.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to conduct skills competencies upon hire for one of five sampled staff (Certified Nurse Assistant 2 [CNA 2]). This failure had the potential for the residents in the facility not to receive appropriate/safe nursing care and services from CNA 2. Findings: During a concurrent record review and interview on 5/7/2026 at 10:20 am with the Assistant Director of Staff Development (ADSD), CNA 2's employee file was reviewed. The ADSD stated CNA 2 was a full-time employee in the facility since 1/13/2026. The ADSD stated CNA 2 did not complete a skills competence upon hire. The ADSD stated skills competency should be done and completed upon hire and yearly by the Director of Staff Development (DSD). During a concurrent record review and interview on 5/7/2026 at 10:25 am with the Director of Nursing (DON), CNA 2's employee file was reviewed. The DON stated CNA 2's skills competency upon hire was not completed and validated by the DSD. The DON stated orientation skill competency should have been completed and validated by the DSD upon hire to ensure employees were competent in providing safe patient care. During a review of the facility's undated Policy and Procedure (P&P) titled, Nursing Staff Competency, the P&P indicated, It is the policy of the facility to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required. The nursing staff member shall complete the orientation competency assessment for the appropriate job category to meet the needs of the facility's resident population in accordance with the facility assessment. The Director of Staff Development or designee must validate all skills for competent performance. Nursing staff member shall complete a competency skills check annually and/ or as needed based on the resident population needs in accordance with the facility assessment.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the pharmacist's recommendation for Protonix (medication used to treat excessive stomach acid) oral tablet delayed release 40 milligrams (mg- unit of measurement) was acted upon for one of one sampled resident (Resident 69). This deficient practice had the potential for Resident 69 to receive unnecessary medication that could lead to adverse side effects.Findings: During a review of Resident 69's admission Record (AR), the AR indicated the facility admitted Resident 69 on 6/30/25 with diagnoses including protein/caloric malnutrition (reduced nutrients leading to changes in body composition and function), chronic kidney disease (the kidneys are damaged and gradually lose their ability to filter blood and remove waste) and gastro-esophageal reflux disease (GERD- stomach acid frequently flows back into the esophagus [the tube that carried food from the mouth to the stomach]) without esophagitis (inflammation of the esophagus). During a review of Resident 69's History and Physical (H&P) dated 9/25/25. the H&P indicated Resident 69 could make needs known but could not make medical decisions. During a review of Resident 69's Minimum Data Set (MDS- a resident assessment tool) dated 4/1/26, the MDS indicated Resident 69 required supervision or touching assistance for toileting hygiene, shower/bathing self, upper body dressing and personal hygiene. During a review of Resident 69's Order Summary Report (OSR) dated 11/26/25, the OSR indicated an active order for Protonix Oral Tablet Delayed Release 40 mg (Pantoprazole Sodium) one tablet by mouth one time a day for GERD, administer before breakfast. During a review of Resident 69's Medication Record Review (MRR) for 4/1/26 - 4/14/26, an undated Note To Attending Physician/Prescriber indicated Resident 69 was currently on pantoprazole. The note indicated, If this resident has been receiving this proton pump inhibitor for more than 12 weeks, please consider reassessing the need for this therapy at this time. If present therapeutic regimen is still indicated, provide explanation that patient requires medication at current dosage. Benefits of continuing medication must outweigh the risks of continuing with current therapy. The note was signed by the provider but undated. The Physician/Prescriber Response (Agree, Disagree, or Other) portion of the note was not checked off. During an interview and record review with the Director of Nursing (DON) on 5/6/2026 at 2:52 PM, the DON stated the Note to Attending Physician/Prescriber was signed by the provider but did not have a date when the form was signed and the Physician/Prescriber Response section was not checked off. The DON stated if the document was not completed, the recommendation was not followed/acted upon since there was no date or prescriber's response section checked off. During an interview and record review with Wound Care Nurse 2 (WCN2) on 5/7/2026 at 2:02 PM, WCN2 stated the Note to Attending Physician/Prescriber for Resident 69 was not dated, and the physician's response section to the pharmacist's recommendation was not checked off. WCN2 stated that since the document was not completed, the nurse should have called the doctor to get clarification because the response section needed to be checked off. During an interview and record review with the Infection Prevention Nurse (IPN) on 5/8/2026 at 7:44 AM, the IPN stated the Note To Attending Physician/Prescriber should be completed by the physician with the physician's signature, date and response to the pharmacist's recommendations. The IPN stated if the physician signed the form but did not date it, the form was not completed, and a licensed nurse should have called and clarified the form. The IPN stated the licensed nursing staff was responsible for ensuring that the pharmacist's recommendations were acted upon. During a review of the facility's undated Policy and Procedure (P&P) titled, Medication Regimen Review (MRR), the P&P indicated, Irregularities will be documented on a report; that is sent to the attending physician, the facility's Medical Director and the Director of Nursing Services and lists the resident's name, the relevant drug, and the irregularity the pharmacist identified. These reports will be acted upon. MRR recommendations to physician:-Any identified medication irregularities or concerns will be reported to the attending physician for review. Recommendations (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and actions taken will be documented in the medical record and or pharmacy documentation system as appropriate. During a review of the facility's undated P&P titled, Physician Services, the P&P indicated it is the policy of the facility that each resident shall be under the care of a licensed physician. 2. Physician services include, but are not limited to:F. Health record progress notes and other appropriate entries in the residents' health records.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent two medication errors out of 28 observed opportunities, yielding a facility medication error rate of 7.14 percent. The Licensed Vocational Nurse (LVN) crushed and administered two medications that should not be crushed for one out of eight sampled residents (Resident 9). These failures increased the risk for the medications to not work as intended, potentially leading to Resident 9 having uncontrolled seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). Findings: During a review of Resident 9's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 9 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including but not limited to epilepsy (a brain condition that causes recurring seizures), chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), and parkinsonism (a group of movement disorders with symptoms such as tremors, slow movement, and rigidity). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 3/2/2026, the MDS indicated Resident 9 has normal thinking and memory abilities. The MDS also indicated Resident 9 does not have difficulty swallowing medications. During a review of Resident 9's physician's order, dated 5/5/2026, the order indicated to administer one tablet of lamotrigine (a medication used to prevent seizures) extended release (ER) 25 milligrams (mg) every 12 hours for epilepsy. Administer along with the 250 mg tablet for a total dose of 275 mg. During a review of Resident 9's second physician's order, dated 5/5/2026, the order indicated to administer one tablet of lamotrigine ER 250 mg every 12 hours for epilepsy. Administer along with the 25 mg tablet for a total dose of 275 mg. During a concurrent observation and interview on 5/6/2026 at 8:32 AM with LVN 2 in Resident 9's room, LVN 2 crushed the lamotrigine ER 25 mg and lamotrigine ER 250 mg into two separate medication cups. LVN 2 mixed apple sauce into each medication cup, then administered the medications to Resident 9. LVN 2 stated she crushed the medications because it is Resident 9's preference. During a concurrent interview and record review on 5/6/2026 at 2:21 PM with LVN 2, Resident 9's physician's orders were reviewed. The physician's orders did not indicate Resident 9's medications were okay to be crushed. LVN 2 stated she did not have an order to crush the medications when she administered the lamotrigine ER 25 mg and 250 mg tablets. LVN 2 stated medications should not be crushed if there is no order. During an interview on 5/6/2026 at 2:24 PM with Registered Nurse (RN) 1, RN 1 stated seizure medications should not be crushed. If a nurse is unsure if a medication can be crushed, they can call the pharmacist to verify. ER means the stomach acid must dissolve the medication over time so you cannot crush ER medications. If an ER medication is crushed, it will not release the medication as it is intended. During a concurrent interview and record review on 5/6/2026 at 2:31 PM with LVN 2, the facility's medication list titled, Oral Dosage Forms That Should Not Be Crushed 2016, undated, was reviewed. The medication list indicated lamotrigine ER should not be crushed. LVN 2 stated she should not have crushed Resident 9's lamotrigine ER 25 mg and lamotrigine ER 250 mg because it could harm the resident by not giving the medication as intended.During a phone interview on 5/7/2026 at 10:46 AM with the facility's Pharmacist Consultant (PC), PC stated Resident 9's lamotrigine ER medications should not be crushed because that is against the manufacturer's recommendations. Crushing the medication would turn it into an immediate release medication, giving Resident 9 her full dose faster than intended. This could potentially result in an increase in seizures.During a phone interview on 5/8/2026 at 11:20 AM with Resident 9's Primary Care Provider (PCP), the PCP stated Resident 9's lamotrigine ER medications should not be crushed because it would defeat the purpose of the ER mechanism of action. Crushing the medication would give Resident 9 her full dose immediately rather than over an extended period. During an interview on 5/8/2026 at 12:43 PM with the Director of Nursing (DON), the DON stated incorrectly crushing lamotrigine ER could cause Resident 9 to have an increase in (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seizures. During a review of the facility's policy and procedure (P&P) titled, Crushing Medications, undated, the P&P indicated the nurse administering medications should refer to the Do Not Crush medication list if not certain about the appropriateness of crushing a specific medication. The facility may also contact the pharmacist for further information. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, undated, the P&P indicated medications must be administered in accordance with good nursing practices and only after the nurse has familiarized themselves with the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent significant medication errors for one of eight sampled residents (Resident 9) when lamotrigine (a medication used to prevent seizures (a sudden, uncontrolled disturbance in the brain which can cause jerking, blank stares, and loss of consciousness)) extended release (ER) tablets were crushed prior to administration. These failures increased the risk for the medication to not work as intended, potentially leading to Resident 9 having uncontrolled seizures.Findings: During a review of Resident 9's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 9 was initially admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses including but not limited to epilepsy (a brain condition that causes recurring seizures), chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), and parkinsonism (a group of movement disorders with symptoms such as tremors, slow movement, and rigidity). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 3/2/2026, the MDS indicated Resident 9 has normal thinking and memory abilities. The MDS also indicated Resident 9 does not have difficulty swallowing medications. During a review of Resident 9's physician's order, dated 5/5/2026, the order indicated to administer one tablet of lamotrigine ER 25 milligrams (mg) every 12 hours for epilepsy. Administer along with the 250 mg tablet for a total dose of 275 mg. During a review of Resident 9's second physician's order, dated 5/5/2026, the order indicated to administer one tablet of lamotrigine ER 250 mg every 12 hours for epilepsy. Administer along with the 25 mg tablet for a total dose of 275 mg. During a concurrent observation and interview on 5/6/2026 at 8:32 AM with Licensed Vocational Nurse (LVN) 2 in Resident 9's room, LVN 2 crushed the lamotrigine ER 25 mg and lamotrigine ER 250 mg into two separate medication cups. LVN 2 mixed apple sauce into each medication cup, then administered the medications to Resident 9. LVN 2 stated she crushed the medications because it is Resident 9's preference. During a concurrent interview and record review on 5/6/2026 at 2:21 PM with LVN 2, Resident 9's physician's orders were reviewed. The physician's orders did not indicate Resident 9's medications were okay to be crushed. LVN 2 stated she did not have an order to crush the medications when she administered the lamotrigine ER 25 mg and 250 mg tablets. LVN 2 stated medications should not be crushed if there is no order. During an interview on 5/6/2026 at 2: 24 PM with Registered Nurse (RN) 1, RN 1 stated seizure medications should not be crushed. If a nurse is unsure if a medication can be crushed, they can call the pharmacist to verify. ER means the stomach acid must dissolve the medication over time so you cannot crush ER medications. If an ER medication is crushed, it will not release the medication as it is intended. During a concurrent interview and record review on 5/6/2026 at 2:31 PM with LVN 2, the facility's medication list titled, Oral Dosage Forms That Should Not Be Crushed 2016, undated, was reviewed. The medication list indicated lamotrigine ER should not be crushed. LVN 2 stated she should not have crushed Resident 9's lamotrigine ER 25 mg and lamotrigine ER 250 mg because it could harm the resident by not giving the medication as intended.During a phone interview on 5/7/2026 at 10:46 AM with the facility's Pharmacist Consultant (PC), PC stated Resident 9's lamotrigine ER medications should not be crushed because that is against the manufacturer's recommendations. Crushing the medication would turn it into an immediate release medication, giving Resident 9 her full dose faster than intended. This could potentially result in an increase in seizures.During a phone interview on 5/8/2026 at 11:20 AM with Resident 9's Primary Care Provider (PCP), the PCP stated Resident 9's lamotrigine ER medications should not be crushed because it would defeat the purpose of the ER mechanism of action. Crushing the medication would give Resident 9 her full dose immediately rather than over an extended period. During an interview on 5/8/2026 at 12:43 PM with the Director of Nursing (DON), the DON stated incorrectly crushing lamotrigine could cause Resident 9 to have an increase in seizures. During a review of the facility's policy and procedure (P&P) titled, Crushing Medications, undated, the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555854	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mesa Glen Care Center	638 E Colorado Avenue Glendora, CA 91740

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P indicated the nurse administering medications should refer to the Do Not Crush medication list if not certain about the appropriateness of crushing a specific medication. The facility may also contact the pharmacist for further information.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain clinical records in accordance with acceptable professional standards of practice for one of one sampled resident (Resident 5) by failing to accurately assess Resident 5's Fall Risk Evaluation (FRE- method of assessing a patient's likelihood of falling) upon admission. This deficient practice had the potential to negatively impact on Resident 5's delivery of services. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted Resident 5 on 3/21/2026 and readmitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and gastrostomy (GT, tube that is placed directly into the stomach through an abdominal wall incision for administration of food, fluids, and medications) status. During a review of Resident 5's FRE dated 3/21/2026, the FRE indicated Resident 5 was assessed as low risk for falls due to intermittent confusion and being bedbound. Resident 5's FRE was not assessed for history of fall, ambulation/elimination status/Systolic blood pressure/Vision status/Predisposing Diseases/ Change in condition in the last 14 days/Recent hospitalization history in last 30 days/Six-month hospitalization notes/Gait (a person's manner of walking) /Balance and Medications. During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 3/26/2026, the MDS indicated, Resident 5 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 5 needed maximum assistance (helper does more than half the effort) from staff for oral hygiene, toileting hygiene, shower, upper/lower body dressing and putting on/taking off footwear. During a concurrent interview on 5/6/2026 at 3 pm with the Director of Nursing (DON), the DON stated Resident 5's FRE was not filled out completely and therefore, Resident 5 was not properly assessed for risk of falls. The DON stated Resident 5's FRE needed to be filled out completely and accurately for staff to implement specific interventions to minimize and prevent falls. During a review of the facility's undated Policy and Procedure (P&P) titled, Charting and Documentation, the P&P indicated The resident's clinical record is a concise account of treatment, care, response to care, signs, symptoms and progress of the resident's condition. Licensed Nurse will document a complete physical and mental nursing assessment within the first 24 hours.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Put firmly secured handrails on each side of hallways. Based on observation, interview, and record review, the facility failed to maintain a safe and secure handrail located in one of one facility hallways at the North Station of the facility building. This deficient practice placed the residents at risk of injury. Findings: During an observation of the facility's handrail located in the hallway at the North Station on 5/6/26 at 8:14 AM, the handrail was not firmly secured to the corridor wall. During an observation and interview with the Director of Nursing (DON) on 5/6/2026 at 10:43 AM, the DON stated the handrail along the wall located in the hallway of the North Station was not secured to the wall. The DON stated if the handrail was not secured, and if a resident was using it, it could cause the resident to lose balance causing a fall. The DON stated the handrail should be secured to keep the residents safe and prevent harm. The DON stated the Maintenance Supervisor (MS) was responsible for maintaining the facility in good condition and safe for the residents. During an observation and interview with the MS on 5/7/2026 at 8:12 AM, the MS stated the handrail located in the hallway in the North Station corridor was not sturdy for the patients to use. The MS stated the handrail was not fixed securely on the wall and three of the handrail mounts attaching the rail to the wall were broken and should have been replaced. The MS stated the MS was responsible for ensuring all the facility handrails were safe and sturdy for the residents to use. The MS stated if a resident used a broken handrail to pick themselves up and if the handrail was not sturdy or fixed securely on the wall, it could cause a resident to lose balance, fall and cause injury. During an interview with the facility's Infection Prevention Nurse (IPN) on 5/8/2026 at 7:57 AM, the IPN stated the facility's handrails should be sturdy and secured on the wall. The IPN stated it was a safety issue for the residents if the handrails were not secured properly to the wall. The IPN stated the residents could suffer a risk for entrapment or fall if the residents were using a handrail not secured or fixed properly to the wall. During a review of the facility's undated Policy and Procedure (P&P) titled Maintenance Department, the P&P indicated it is the policy of the facility to maintain a clean and safe facility and grounds. This is maintained through: A program of scheduled inspectionsPreventative MaintenanceCorrective Maintenance During a record review of the facility's undated P&P titled Physical Environment, the P&P indicated, It is the policy of the facility to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public though monthly environmental rounds. The following environmental conditions shall be included in the Monthly Environmental Rounds: Equip corridors with firmly secured handrails on each side. During a review of the facility's undated P&P titled Homelike Environment, the P&P indicated to provide a homelike environment for residents.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents' room was free from pests (any living organism such as bugs or rodents that can transmit disease) for two of four sampled residents (Resident 23 and 64) when a bug was found in Resident 23 and 64's shared room. This failure had the potential to increase Resident 23 and 64's risk of infection and emotional distress.Findings: During a review of Resident 23's admission Record (face sheet), dated 5/7/2026, the face sheet indicated Resident 23 was admitted to the facility on [DATE] with diagnoses including but not limited to cervical disc disorder (the breakdown of the cushion-like pads separating the bones in the neck), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder (a mental health condition that causes intense and constant feelings of worry and fear). During a review of Resident 23's History and Physical (H&P), dated 3/5/2026, the H&P indicated Resident 23 has the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 23 has no impairment to upper or lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, foot). During a review of Resident 64's face sheet, dated 5/7/2026, the face sheet indicated Resident 64 was admitted to the facility on [DATE] with diagnoses including but not limited to type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), cerebral infarction (stroke, loss of blood flow to a part of the brain), and hypertensive chronic kidney disease (a condition where long-term high blood pressure damages the blood vessels of the kidneys). During a review of Resident 64's H&P, dated 8/14/2025, the H&P indicated Resident 64 has the capacity to make her needs known. During a review of Resident 64's MDS, dated [DATE], the MDS indicated Resident 64 is capable of normal cognition and memory. During a concurrent observation and interview on 5/6/2026 at 9:50 AM with Resident 23 and 64 in their shared room, a bug was observed crushed in the bathroom door frame. The bug was brown and about three inches long. Resident 23 stated she used the bathroom door to crush the bug last night after using her bathroom. Resident 23 stated this was just one of many bugs she has seen in the facility. Resident 23 further stated it makes her feel grossed out and scared seeing bugs in her room. Resident 64 stated she sees bugs in their room all the time and they are dirty. During a concurrent observation and interview on 5/6/2026 at 9:56 AM with Certified Nurse Assistant (CNA) 2 in Resident 23 and 64's room, the bug was crushed in the bathroom door frame. CNA 2 stated the bug should not be in the room. It is a safety risk and infection risk for the residents. During a concurrent observation and interview on 5/6/2026 at 10:00 AM with Housekeeper (HSK) 1 in Resident 23 and 64's room, the bug was crushed in the bathroom door frame. HSK 1 stated the bug looks like a cockroach. Sometimes she has seen them come into the rooms from outside the facility. It should not be in the residents' room because they have bacteria and could spread to the residents. During an interview on 5/6/2026 at 10:33 AM with the Maintenance Supervisor (MS), the MS stated sometimes water bugs come out a day after it rains. Bugs should not be in residents' bathrooms because they are dirty and can bring in germs. It is an infection risk for the residents. Pest control has come out in the past, but they will need to come back to do more treatments.During an interview on 5/6/2026 at 10:49 AM with the Director of Nursing (DON), the DON stated it is not sanitary to have bugs in the facility, especially in residents' rooms. It is an infection control issue and is not sanitary for the residents. During an interview on 5/6/2026 at 11:02 AM with the Infection Preventionist Nurse (IPN), the IPN stated there should not be any bugs or pests inside the facility. Pests can carry disease and place residents at a high risk for infection.During a review of the facility's policy and procedure (P&P) titled, Pest Control, undated, the P&P indicated the facility must maintain a clean, safe, and sanitary environment free from insects, rodents, and other pests.