STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555859	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure five of five final sampled residents (Residents 1, 7, 13, 22, and 40) reviewed for unnecessary medications were appropriately monitored for the identified manifested episode of behavior and provided with the non pharmacological interventions for the use of psychotropic medications. * Resident 7's medical record did not have documentation of the non pharmacological interventions prior to the administration of the medications, and no monthly summary of behaviors targeted for the use of Seroquel (antipsychotic medication that treats schizophrenia and bipolar disorder), Ativan (anxiety medications), and divalproex (a mood-stabilizing medication) medications.* Resident 13's medical record did not have documentation of the non pharmacological interventions prior to the administration of the medications, and no recent monthly summary of behaviors targeted for the use of clonazepam (an antianxiety medication), and fluoxetine (an antidepressant medication) medications, * Resident 1 was not monitored for the hours of sleep for the use of trazodone (antidepressant) medication for depression as manifested by inability to sleep. In addition, there was no non pharmacological interventions provided for the use of sertraline (antidepressant) for depression as manifested by constant worrying about health. * Resident 22's medical record did not have documentation of the non pharmacological interventions prior to the administration of PRN hydroxyzine (antianxiety) medication for anxiety manifested by physical restlessness. * Resident 40's medical record did not have documentation of the non pharmacological interventions prior to the administration of quetiapine (antipsychotic) medication. These failures had the potential for the residents to receive unnecessary psychotropic medications. Findings: Review of the facility's P&P titled Unnecessary Medications and Psychotropic Drugs/Antipsychotic Medication released November 2022 showed the importance of implementing individualized, non-pharmacological approaches to care prior to the use of medications to minimize the need for medications or reduce the dose and duration of those medications. 1. Medical record review for Resident 7 was initiated on 1/28/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Physician Order Sheet for January 2026 showed the following: - An order dated 12/31/25, for Seroquel 25 mg via GT every 12 hours for depressive episodes m/b social isolation.- An order dated 12/31/25, for divalproex 125 mg delayed release via GT at bedtime for mood swings. - An order dated 12/31/25, for Ativan 0.5 mg via GT every eight hours as needed for anxiety manifested by restlessness. a. Review of Resident 7's MAR for January 2026 showed the Ativan was administered as needed 35 (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times. Non pharmacological interventions were documented as implemented for four of the 35 doses (with 31 doses administered without non pharmacological interventions documented). Review of Resident 7's medical record failed to show non pharmacological interventions were implemented for the routine Seroquel and divalproex medications. The medical record also failed to show additional documentation of the non pharmacological interventions for any of the remaining 31 doses of the Ativan PRN administered. On 2/2/26 at 0937 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 5. RN 5 reviewed Resident 7's physician's orders above and stated the non pharmacological interventions were not implemented for the routine administration of psychotropic medications. RN 5 reviewed Resident 7's medical record and verified the resident received Ativan PRN without documented non pharmacological interventions. b. Review of Resident 7's medical record failed to show monthly behavior summaries were readily available for review. On 2/2/26 at 1010 hours, an interview and concurrent record review for Resident 7 was conducted with the SSD. The SSD stated she completed the monthly behavior monitoring every quarter, on the same schedule the residents' MDS assessments were due. The SSD stated since Resident 7 was admitted to the facility on [DATE], she would not be doing Resident 7's monthly behavior summary counts until his quarterly MDS assessment is due in March 2026. 2. Medical record review for Resident 13 was initiated on 1/28/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Physician Order Sheet for January 2026 showed the following: - An order dated 12/31/25, for clonazepam 0.5 mg daily for anxiety manifested by the inability to relax.- An order dated 12/31/25, for fluoxetine 10 mg daily for depression, manifested by a sad facial expression. a. Review of Resident 13's medical record failed to show non pharmacological interventions were implemented for the routine use of Seroquel and divalproex medications. On 2/2/26 at 0937 hours, an interview and concurrent record review for Resident 13 was conducted with RN 5. RN 5 stated the non pharmacological interventions were not implemented for the routine administration of the psychotropic medications. RN 5 verified Resident 13's medical record failed to show non pharmacological interventions were implemented to decrease the need for psychotropic medications. b. Review of Resident 13's Social Services progress note dated 12/16/25, showed a breakdown of the resident's tallied behaviors being monitored for September, October, and November 2025. No other recent monthly behavior monitoring were tallied since November 2025. On 2/2/26 at 1010 hours, an interview and concurrent medical record review for Resident 13 was conducted with he SSD. The SSD stated she completed the monthly behavior monitoring every quarter, on the same schedule the residents' MDS assessments were due. The SSD stated Resident 13's last quarterly MDS was done 12/17/25, so she won't be doing her monthly breakdown behavior (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring until March 2026, when the next MDS assessment is due. 3. Medical record review for Resident 1 was initiated on 1/28/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 12/5/25, showed Resident 1 had the capacity to understand and make healthcare decisions. Review of Resident 1's Physician Order Sheet dated January 2026 showed the following orders: - order dated 12/31/25, for trazodone 50 mg tablet, to give 25 mg via GT for depression as manifested by difficulty falling asleep at hour of sleep. - order dated 1/23/26, for sertraline 50 mg, one tablet via GT everyday for depression as manifested by constant worries about health. a. Further review of Resident 1's medical record did not show if hours of sleep were monitored for the use of trazodone. b. Further review of Resident 1's Non PRN Treatment Notes dated January 2026 showed Resident 1 had the behaviors of sad mood on 1/27 and 1/28/26. Review of Resident 1's medical record did not show if non pharmacological interventions were provided to Resident 1 when the resident had sad mood on the above dates. On 2/2/26 at 0850 hours, an interview and concurrent medical record review was conducted with RN 6. RN 6 verified the above findings and stated she was not able to find the documentation if the hours of sleep were monitored for the use of trazodone for Resident 1. RN 6 stated the hours of sleep should have been monitored for the use of trazodone for Resident 1. RN 6 verified she was not able to find documentation if non pharmacological interventions were provided for the use of sertraline when Resident 1 had the behavior related to the use of sertraline medication. 4. Medical record review for Resident 22 was initiated on 1/28/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Physician Order Sheet dated January 2026 showed a physician's order dated 1/27/26, for hydroxyzine 25 mg tablet (one tablet) as needed every 6 hours via GT for anxiety as manifested by physical restlessness. Review of Resident 22's MAR dated January 2026 showed a physician's order dated 1/27/26, for hydroxyzine 25 mg tablet (one tablet) as needed every 6 hours via GT for anxiety as manifested by physical restlessness. Further review of the MAR showed the above medication was administered on 1/28/26. Review of Resident 22's medical record did not show if non pharmacological interventions were provided prior to the administration of the above medication. On 2/2/26 at 0854 hours, an interview and concurrent medical record review for Resident 22 was conducted with RN 6. RN 6 verified the medication hydroxyzine PRN was administered to Resident 22, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and stated she was not able to find the documentation if non pharmacological interventions were provided prior to the administration of hydroxyzine PRN to Resident 22. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings. 3. Medical record review for Resident 40 was initiated on 1/30/26. Resident 40 was readmitted to the facility on [DATE]. Review of Resident 40's H&P exam dated 1/1/26 showed Resident 40's diagnoses included schizoaffective disorder. Review of Resident 40's January 2026 Physician Order Sheet showed Resident 40 had an order dated 1/22/26 for quetiapine (antipsychotic) 50 mg every 8 hours for behavior manifestations of yelling and crying disruptive behavior. Further review of this Order Sheet showed an order dated 1/25/26 for monitoring behaviors for Resident 40's use of quetiapine. Review of Resident 40's January 2026 Medications list showed Resident 40 was administered his Seroquel, however, no non-pharmacological interventions were documented on this list. Further review of Resident 40's medical record failed to show documented evidence non-pharmacological interventions were attempted prior to administering Resident 40 the quetiapine. On 1/30/26, at 1434 hours, a follow up was conducted with the Medical Records Director to request documentation related to documented evidence of non-pharmacological interventions attempted prior to the use of quetiapine. On 1/30/26, at 1545 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were notified of the findings and acknowledged the findings. On 2/5/26, no documentation was received from the facility for the above finding.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medications were administered as ordered by the physician, properly accounted for, and destroyed per pharmaceutical protocols. * Resident 7's Ativan (a controlled medication for anxiety) administration log did not match the administration record and the physician's orders. * Resident 7's midodrine (a medication to treat low blood pressure) was administered outside of the ordered parameters.* Resident 13's midodrine was administered outside of the ordered parameters.* The facility failed to ensure medication destruction was completed by two licensed nurses.* Resident 46's controlled medication log did not match the administration record. These failures had the potential for the medications to be administered in error and opportunities for drug diversion or drug misuse, in addition an undesirable outcome from medications not being administered per the physicians' orders.Findings: Review of the facility's P&P titled General Dose Preparation and Medication Administration revised [DATE], showed to ensure the MAR reflects the most recent medication order, and verify the correct dose to be administered. 1. Medical record review for Resident 7 was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Controlled or Antibiotic Drug Record for Ativan 0.5 mg tablets showed the following: -On [DATE] at 1627 hours, one tablet was removed from the medication supply.-On [DATE] at 0500 hours, one 0.5 tablet was removed from the medication supply. Review of Resident 7's MAR for [DATE], showed the following:-A physician's order dated [DATE], for Ativan 0.5 mg via GT PRN every eight hours for anxiety. The order was discontinued on [DATE]. -The MAR failed to show the Ativan 0.5 mg tablet removed from the medication supply on [DATE] at 1627 hours, was documented as administered. -A physician's order dated [DATE], for Ativan 1 mg via GT PRN every eight hours for anxiety. -The MAR showed 1 mg was documented as administered on [DATE] at 0501 hours; however only one 0.5 mg tablet was removed from the medication supply. On [DATE] at 1057 hours, an interview and concurrent medical record review was conducted with the DON. The DON verified the Ativan 0.5 mg tablet removed from Resident 7's medication supply on [DATE] at 1627 hours, was not documented as administered on the MAR. Upon further review of the resident's EHR, the physician's order for Ativan 0.5 mg was discontinued on [DATE] at 1159 hours, and a new order was obtained at 1722 hours for Ativan 1 mg PRN. The DON stated there was no active physician's order for Ativan 0.5 mg at 1627 hours, and the nurse should have verified a physician's order was in place before removing and/or administering the medication. In addition, with the new order placed at 1722 hours, for Ativan 1 mg PRN, the incorrect dose of 0.5 mg was removed on [DATE] at 0500 hours, and two tablets should have been removed and administered for the correct medication dose ordered. 2. Medical record review for Resident 7 was initiated on [DATE]. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Physician Order Sheet [DATE] showed a physician's order dated [DATE], for midodrine 5 mg via GT every eight hours, and to hold for a SBP greater than 130. Review of Resident 7's MAR for [DATE] showed the resident had an order for midodrine 5mg to be administered via GT every eight hours, and to hold for a SBP greater than 130. The MAR showed midodrine was documented as administered with an SBP greater than 130 on the following dates:-On [DATE] at 2000 hours, with an SBP 134;-On [DATE] at 0600 hours, with an SBP 150; -On [DATE] at 2200 hours, with an SBP 143;-On [DATE] at 0600 hours, with an SBP 152;-On [DATE] at 0600 hours, with an SBP 134; and-On [DATE] at 0600 hours, with an SBP 133. On [DATE] at 0937 hours, RN 5 reviewed Residents 7's MAR for [DATE] and verified the midodrine medication was documented as administered outside of the ordered parameters. 3. Medical record review for Resident 13 was initiated on [DATE]. Resident 13 was admitted on [DATE]. Review of Resident 13's Physician Order Sheet for [DATE] showed a physician's order dated [DATE], for midodrine 10 mg via GT every 12 hours, and to hold for (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a SBP greater than 130. Review of Resident 13's MAR for [DATE] showed a physician's order for midodrine 10 mg to be administered via GT every 12 hours, and to hold for a SBP greater than 130. The MAR showed on [DATE] at 0900 hours, the midodrine medication was administered with a SBP of 139 (above the ordered hold parameter for a SBP greater than 130). On [DATE] at 0937 hours, RN 5 reviewed Residents 13's MAR for [DATE] and verified the midodrine medication was documented as administered outside of the ordered parameters. 4. Review of the facility's P&P titled Disposal/Destruction of Expired or Discontinued Medication revised [DATE], showed an RN should destroy non-controlled medications witnessed by one other staff. The drug destruction form should show the signatures of the staff destroying and witnessing the destruction. Review of the facility's Drug Disposition Logs showed the following:-On [DATE], 14 tablets of Eliquis (a blood thinner) and eight tablets of folic acid (supplements) were destroyed. There were no signatures for the RN who destroyed the medication, and the staff who witnessed the destruction. -On [DATE], the following medications were documented as destroyed without a witness signature:* 18 tablets of acetaminophen (a mild pain reliever)* 16 tablets of metoclopramide (a medication for gastroesophageal reflux)* eight tablets of furosemide (a diuretic)* seven tablets of amlodipine besylate (a medication for high blood pressure)* 10 tablets of metoprolol tartrate (a medication for high blood pressure)* 14 tablets of losartan potassium (a medication for high blood pressure)* 12 tablets of propranolol (a medication for high blood pressure and irregular heartbeats)* 37 tablets of Sucralfate (a medication used to treat and prevent ulcers and gastroesophageal reflux)-On [DATE], the following medications were documented as destroyed without a witness signature:* 15 tablets of glipizide (a medication used to lower blood sugar)* seven tablets of simethicone (a medication used to relieve painful symptoms of excess gas)* nine lidocaine (a topical pain medication) patches* seven tablets of Eliquis On [DATE] at 1321 hours, an interview and concurrent record review was conducted with the DON. The DON reviewed the facility's P&P and verified an RN and a witness should conduct medication destruction. The DON verified the above Drug Disposition Logs did not show they were destroyed per protocols. 5. On [DATE] at 1108 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 7. A bubble pack of Resident 46's hydrocodone 5mg - acetaminophen 325 mg tablets (controlled pain medications) was observed with 11 tablets remaining. Review of the medication's Controlled or Antibiotic Drug Record showed a balance of 12 tablets, with the last dose being administered on [DATE] at 2016 hours. RN 7 stated she removed one tablet at 0900 hours, and forgot to sign it out in the drug record. RN 7 stated the process when removing a controlled medication from the Controlled or Antibiotic Drug Record is to sign it out when it is removed. On [DATE] at 1321 hours, an interview was conducted with the DON. The DON stated the controlled medications should be signed out on the Controlled or Antibiotic Drug Record when it was removed from the medication supply.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility P&P review, the facility failed to ensure the proper storage and labeling of medications and biologicals in one of one medication rooms observed (Medication Room A), and two of five medication carts observed (Medication Carts A and B) and at two non-sampled residents bedside (Residents 35 and 41) were followed. * Medication Room A's medication destruction incinerator container was not secured, and the medications were not effectively destroyed. * Two bottles of compounded Vancomycin (medication to treat infections), past their labeled use by date, were in Medication Room A's refrigerator. * RN 7 left Medication Cart B unlocked and unattended.* An open bottle of glucometer test strips in Medication Cart B was not labeled with the date opened and the use-by date. * A bottle of Pro-Stat (liquid protein supplement to aid in wound healing) had a sticky residue, as well as a damaged pharmacy label. * The facility failed to ensure the medication triad hydrophilic wound dressing was not left unattended inside the resident's room. These failures had the potential for staff and residents having unauthorized access to medications, a risk of expired medications being administered to the residents, and improper labeling. Findings: Review of the facility's P&P titled Storage and Expiration of Medications and Biologicals revised 6/30/25, showed: -All medications and biologicals are securely stored in a locked cabinet or cart. -Expired medications should be stored separately from other medications until destroyed. Review of the facility's P&P titled General Dose Preparation and Medication Administration revised 11/15/24, showed to ensure medication carts are always locked when out of sight or unattended. 1. On 1/30/26 at 1306 hours, during an inspection of Medication Room A and concurrent interview with RN 4, a plastic container was observed on the floor. RN 4 stated it was the medication destruction incinerator. The lid to the incinerator easily slid fully back, and the inside of the incinerator was observed with multiple medications in their original form including five unopened vials of ondansetron (medication to prevent and treat nausea and vomiting), multiple additional vials with liquid still inside, multiple intact tablets and capsules, a bag of 0.9% Sodium Chloride (solution used to treat low sodium levels and prevent dehydration) attached to a vial of undiluted powder, and sealed packages of suppositories. All the medications could easily be retrieved from the container. RN 7 verified the incinerator was easily opened, and the medications inside were intact and removable. On 1/30/26 at 1321 hours, an interview was conducted with the DON. The DON stated the medications placed in the incinerator should be destroyed so they were not usable. The DON stated when he destroyed medications with the pharmacist, the vials were destroyed and liquid was added to the incinerator to destroy the medications. 2. On 1/30/26 at 1306 hours, an inspection of the refrigerator in Medication Room A and concurrent interview was conducted with RN 4. Two bottles of compounded Vancomycin were observed. One bottle showed an expiration date of 1/1/26, and the other bottle was labeled to discard by 1/26/26. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 4 verified the bottles should have been discarded. 3. On 1/29/26 at 1408 hours, Resident 40's medication administration observation was conducted with RN 7. After retrieving Resident 40's medications from Medication Cart B, RN 7 left the medication unlocked in the hallway, walked two doorways down from the medication cart into Resident 40's room and donned PPE (Personal Protective Equipment). Two EVS (Environmental Services) staff were in the hallway, next to the unlocked Medication Cart B. RN 7 verified she left the cart unlocked and unattended, and should have locked the medication cart before walking away. 4. On 1/30/26 at 1108 hours, an inspection of Medication Cart B and concurrent interview was conducted with RN 7. Inside Medication Cart B, an open bottle of glucometer (a portable device used to test blood sugar levels) test strips was observed in the medication cart. The bottle label had Open__/__/__ and Discard __/__/__ typed on it. The dates were left blank. RN 7 stated she had used the test strips, but the bottle was open before she started her shift. RN 7 verified the bottle should be dated for when it was opened and when to discard, as the test strips were only good for six months once opened. On 2/2/26 at 0755 hours, an observation and concurrent interview was conducted with the DSD. The DSD stated the glucometer test strips should be dated when opened and when to discard, 180 days after opening. The DSD pointed to the signage posted in her office which showed the test strips were good for 180 days, and must be labeled with both open and discard dates. 5. On 1/29/26 at 0821 hours, during a medication administration observation with LVN 2, Resident 13's bottle of Pro-Stat was observed in Medication Cart A with a torn, stained, and sticky pharmacy label, as well as the bottle had sticky residue coming from the bottle neck extending down the bottle. LVN 2 verified the bottle needed to be cleaned and the pharmacy label was torn, sticky, and stained. 6. Review of the facility P&P titled Storage and Expiration Dating of Medications and Biologicals revised 6/30/25, showed the facility staff should ensure all medication and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. On 1/28/26 at 0838 hours, a medication Triad hydrophilic wound dressing was observed stored in Room A at the window close to Resident 35's bed (Bed B). No label was observed on the medication. On 1/28/26 at 0840 hours, an observation and concurrent interview was conducted with RN 1. RN 1 verified the observation and stated the medication should not have been stored at the bedside. RN 1 stated both of the residents in Room A were not able to self-administer medications and the staff should not have left the medication at the bedside. RN 1 was then observed taking the medication out of the room. a. Medical record review for Resident 35 was initiated on 1/28/26. Resident 35 was admitted to the facility on [DATE]. Review of Resident 35's H&P examination dated 12/17/25, showed Resident 35 had no medical decision-making capacity. Review of Resident 35's Physician Order Sheet dated January 2026 did not show an order for the Triad medication. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. Medical record review for Resident 41 was initiated on 1/28/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's H&P examination dated 1/19/26, showed Resident 41 had the capacity to understand choices and make health care decisions. Review of the Resident 41's Physician Order Sheet dated January 2026 showed a physician's order dated 1/17/26, for house barrier cream to perineal area for maintenance to apply every shift. On 1/28/26 at 0840 hours, an interview and concurrent medical record review for Residents 35 and 41 was conducted with LVN 1. LVN 1 was informed the medication Triad was observed at the bedside close to Resident 35. LVN 1 verified the above findings and stated Resident 35 did not have the order for the medication Triad. LVN 1 also verified Resident 41 had the physician's order for the house barrier cream to perineal area for maintenance to apply every shift. LVN 1 stated the facility used the Triad medication as a house barrier cream. LVN 1 stated the Triad medication should not have been left at the bedside. On 2/2/26 at 0941 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure the sanitation in the kitchen was maintained. * There was no thermometer inside the reach in refrigerator,* One box of opened gloves and two boxes of aluminum sheets were stored inside the reach in refrigerator.* Two racks inside the reach in refrigerator had brown discoloration.* Expired items were stored on the kitchen countertop.* Two bottles of expired Ensure were stored inside the residents' refrigerator * One sanitizer bucket was stored near food items.* Food stored in the steam table did not reach the appropriate temperatures.* Temperature log for dish washing machine was not completed for 2 days.* Two staff did not know the location of the emergency food storage. * Three male kitchen staff were observed with their beard restraints placed underneath their moustaches, not fully covering their facial hair.* There was no can opener readily available to open canned food items in dry food/emergency food supply storage room. These failures posed the risk of food-borne injury to the residents and of not being able to readily access the emergency food supplies in case of an emergency. Findings: Review of the facility's Patients Diet List for residents showed a total of 12 of 36 residents received food prepared in the facility's kitchen. 1a. On 01/28/2026 at 0750 hours, a tour of the facility's kitchen and concurrent interview was conducted with Dietary Manager 1. The following was observed: A red bucket containing sanitizing solution was observed near the food items on a counter. A reach in refrigerator containing food items was observed without a thermometer and with brown discoloration on two of the refrigerator racks. Also, a pack of gloves and two packs of aluminum sheets were observed stored inside the reach in refrigerator. A kitchen counter located near the facility's dry food storage room was observed with one bag of corn meal with an expiration date of 12/25 and one bag of tempura shrimp without an expiration date. Inside a refrigerator located across the facility's stove was a bag of tortillas observed with a use by 12/18/25. When asked about the dishwashing room, Dietary Manager 1 stated the three compartment manual dishwashing sink was not working. When asked about the food preparation sink missing the knobs on the faucet, Dietary Manager 1 stated it was not working. The following observations were verified with Dietary Manager 1. 1b. On 1/28/26 at 0905 hours, an observation and concurrent interview was conducted with RN 1 for the residents' refrigerator. Inside the refrigerator, two bottles of Ensure (nutritional supplement) were observed with an expiration date of 11/1/24. RN 1 verified the findings. 1c. On 1/29/26 at 0810 hours, during a follow up visit to the facility's kitchen, a total of three male kitchen staff (Culinary Aides 1, 2, and 3) were observed with their beard restraints placed underneath their moustaches, not fully covering their facial hair. The findings were verified with Dietary Manager 1. 1d. On 1/29/26 at 1050 hours, a machine dishwashing observation was conducted with Culinary Aide 1 and Dietary Manager 1. When asked about checking the dishwasher's temperature and documenting the temperature, Dietary Manager 1 verified the temperature for 1/27 and 1/28/26 were not completed for the dishwasher. 1e. Review of the facility's P&P titled Procedure Dishwashing Dish Machine, reviewed 10/2025 showed steps to doing the dishwashing included testing the dish machine for proper temperatures and recording readings prior to washing the dishware. On 1/29/26 at 1135 hours, a trayline observation was conducted with Dietary Manager 2. Dietary Manager 2 stated she would be obtaining the temperature for the food items in the steam table which would be served for lunch to the residents. The steam table consisted of a total of five compartments. Two of the steam table compartments were observed not having steam coming out of them. Dietary Manager 2 took the temperature of the beef items and stated the temperature of the chopped beef was 90 degrees Fahrenheit. Dietary Manager 2 lifted the steamtable pan containing the beef and other pans containing food items. Dietary Manager 2 verified the compartment did not have steam coming out of it. Dietary Manager 2 verified the water contained underneath the steamtable pans was not hot to the touch. Dietary Manager 2 took (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the temperature of mashed potatoes placed in another steam table compartment and stated the temperature was 101 degrees Fahrenheit. Dietary Manager 2 verified this compartment also did not have steam coming out of it. Dietary Manager 2 verified the water contained underneath the steamtable pans was not hot to the touch. Both of the knobs on these steam table compartments did not have a light on the know to show whether they were working. This findings were verified with Dietary Manager 2. The lunch menu to be served to residents on 1/29/26, included braised beef, peas & carrots, mashed potatoes, and green beans. 1f. On 1/29/26 at 1509 hours, an interview with RD 1 was conducted. When asked about the location of the emergency food storage, RD 1 stated it was in the dry food storage area, inside the facility's kitchen. On 1/30/26, at 1111 hours, an observation and concurrent interview was conducted with RN 1. When asked about where the enteral feedings were stored, RN 1 showed a closet containing the unit's enteral feedings (including Jevity and Glucerna) and nutritional supplements (including Glucerna, Ensure and Nepro). The closet was observed not having a thermometer in place. When asked about a thermometer to ensure the enteral feedings were kept at room temperature, RN 1 verified there was no thermometer inside the closet for the enteral feedings. When asked about the emergency food storage location, RN 1 stated she did not know the location of the emergency food storage. According to [NAME].com, enteral feedings including Jevity, and nutritional supplements including Glucerna were to be stored at room temperature when unopened. On 1/30/26, at 1123 hours, an observation and concurrent interview was conducted with the DSD. When asked about the emergency food storage location, the DSD stated she did not know the location of the emergency food storage. The DSD stated she would do a follow up with the Administrator. The Administrator and RD 2 showed the location of the emergency food supply; in the dry storage food area inside the facility's kitchen. When asked about a can opener to open the canned food items inside the dry storage/emergency food area, both the Administrator and RD 2 verified there were no can openers readily available to open the canned items in case of an emergency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to maintain the infection prevention control program and practices designed to provide a safe and sanitary environment to help prevent the transmission of communicable diseases and infections. * The facility failed to maintain an accurate infection control surveillance program for November and December 2025, and January 2026. The facility conducted surveillance only for the residents who exhibited signs and symptoms of infection and were prescribed antimicrobial medications. * The facility failed to ensure the staff performed hand washing after changing trash liner in a room with Clostridium difficile (a bacteria that causes diarrhea, and is usually a side-effect of taking antibiotics) for Resident 3. * The facility failed to ensure the staff performed hand hygiene after administering GT medication and before administering subcutaneous medication for Resident 18 . These failures had the potential to spread infection in the facility.Findings: 1.Review of the facility P&P titled Infection Prevention and Control Program dated 1/2022 showed infection prevention and control strategies and risk control measures are based on data collection from surveillance activities pertaining to patients, healthcare environment, licensed independent practitioners, physicians, staff, volunteers, students, trainees, visitors and families. The facility designates an infection preventionist (IP) to coordinate the infection prevention and control program: - Develops goals for the infection prevention and control program based on an annual risk assessment, geographical location and the community served. - Collects analysis and provides infection related data and trends to the infection prevention and control committee as well as shared trends with the staff responsible for providing care to the patient. - Ensures that there is routine, ongoing collection, analysis, interpretation and dissemination of data to identify healthcare associated infection and community acquired infection, infection risks, communicable outbreaks and maintain or improve patient health status. On 1/29/26 at 1019 hours, an interview and concurrent facility document review was conducted with the IP/DSD. The IP/DSD was asked to show the facility's infection control surveillance program for November and December 2025, and January 2026. Review of the Infection Prevention and Control Surveillance Log for November and December 2025, and January 2026 showed the infection control surveillance was only conducted for the residents who exhibited signs and symptoms of infection and were prescribed with antibiotics. There was no documented evidence of surveillance for the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications, such as the residents with viral infection and the infection that were not prescribed antibiotic were included in the surveillance log. When the IP/DSD was asked to describe the facility's infection surveillance program, the IP/DSD stated she would initially do an order listing report from the electronic health record and select the residents on antibiotic treatment and run the report. The IP/DSD stated she would then manually enter the information of the residents prescribed with antibiotics to the surveillance log. The IP/DSD stated she conducted surveillance only on the residents with infections who were prescribed antimicrobial medications. When asked if the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications were included in the surveillance, the IP stated she did not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	include the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications. The IP/DSD stated she should have included the residents who exhibited signs and symptoms of infection but were not prescribed antimicrobial medications in the surveillance log. On 2/2/26 at 0941 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's Guidelines- Clostridioides difficile (C. diff) P&P reviewed June 2023 showed for confirmed C. diff infections, contact precautions should be implemented and hand hygiene with soap and water should be performed before exiting the room. Medical record review for Resident 3 was initiated on 1/28/26. Resident 3 was admitted on [DATE]. Review of Resident 3's Physician Order Sheet showed an order dated 1/21/26, for contact isolation for C. diff. On 1/28/26 at 0748 hours, a contact isolation signage was observed posted outside Resident 3's doorway. LVN 2 stated Resident 3 was on contact isolation for C. diff. On 1/28/26 at 0803 hours, an observation and concurrent interview was conducted with EVS Staff 1. EVS Staff 1 was observed placing something inside of the trash receptable located inside Resident 3's room. EVS Staff 1 used ABHR (Alcohol Based Hand Rub) left the resident's room, and proceeded to go to another resident's room. EVS Staff 1 stated she was placing the new trash bag into the trash receptacle and did not need to wash her hands because the trash was already emptied by someone else. The signage above the trash can inside the room showed to wash hands with soap and water. On 1/28/26 at 0850 hours, an interview was conducted with the DSD/IP. The DSD/IP stated Resident 3's trash bin was not a clean surface and EVS Staff 1 should have washed her hands, as ABHR was not appropriate for C. diff. 3. Review of the facility's P&P titled Medication Administered through an Enteral Tube revised 11/15/24, showed after administering GT medications, remove gloves and perform hand hygiene. Review of the facility's P&P titled Medication Administration through Certain Routes of Administrations revised 11/15/24, showed for SC (subcutaneous) injections, to perform hand hygiene and apply clean gloves in preparation for administering the SC injection. On 1/29/26 at 0914 hours, a medication observation for Resident 18 was conducted with RN 4. RN 4 was observed performing hand hygiene and donning gloves prior to administering the GT medications. After administering the GT medications, RN 4 then administered a SC injection into the resident's abdomen. RN 4 verified she failed to change her gloves and perform hand hygiene between the GT and SC medications, and should have. On 1/29/26 at 1533 hours, an interview was conducted with the DSD/IP. The DSD/IP stated the staff should remove their gloves, perform hand hygiene, and apply new gloves when moving from GT medications administration to SC medication injection administration.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the education regarding the risks and benefits of the influenza and pneumococcal vaccinations were reviewed with the resident and/or resident representative for five of six residents (Residents 27, 8, 1, 18, and 3) reviewed for immunization. * The facility failed to ensure Resident 1 was provided with the education on the risks, benefits, and potential side effects of pneumococcal vaccination before the administration of the pneumococcal vaccination to Resident 1. In addition, the facility failed to ensure the updated VIS (Vaccination Information Sheet) was provided to Resident 1 before the administration of the pneumococcal vaccination. * The facility failed to provide the education on the risks, benefits, and potential side effects of influenza and pneumococcal vaccination to the resident and/or their representative when Resident 8 did not have records of influenza and pneumococcal vaccination. * The facility failed to provide the education on risks, benefits, and potential side effects of influenza to Resident 27 and/or their representative before the administration of the influenza vaccination. * The facility failed to ensure Resident 18 and/or their representative were provided with the education on the risks, benefits, and potential side effects when the residents declined the influenza and pneumococcal vaccination. * The facility failed to ensure Resident 3 and/or their representative were provided with the education on the risks, benefits, and potential side effects of influenza and pneumococcal vaccination when Resident 3's representative declined the influenza vaccine for Resident 3, and when Resident 3 received the pneumococcal vaccine on 10/11/25. These failures had the potential for the residents and/or their representatives of not being informed of the influenza and pneumococcal vaccination, the benefits, risks, and potential side effects of influenza and pneumococcal vaccination to make an informed decision.Findings: Review of the facility P&P titled Immunization dated 10/2022 showed the facility offered both the influenza and pneumococcal immunization to minimize the risk of acquiring transmitting, or experiencing complications from influenza and pneumococcal pneumonia is minimized of the patient and staff. Under the procedure section showed an opportunity to receive the influenza and pneumococcal vaccine is provided unless medically contraindicated or refused or already immunized. Further review of the P&P showed the information/education provided regarding the benefits and risks of immunization is documented in the patient medical record. 1. Medical record review for Resident 1 was initiated on 1/28/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 12/5/25, showed Resident 1 had the capacity to understand and make healthcare decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of the facility document titled Resident Vaccine log (Flu/pneumococcal/COVID-19) dated 2025-26 showed Resident 1 received pneumococcal vaccination in the facility on 12/1/25. Review of Resident 1's Vaccine VIS Acknowledgement and Consent dated 12/5/25, showed under the section Vaccine Information Sheet (VIS), the following VIS was marked as provided:Inactive influenza Vaccine, edition 8/15/2019Pneumococcal Conjugate (PCV 13) dated 11/5/15 Under the section date, the above VIS provided showed the Inactive influenza Vaccine, edition 8/15/2019, was provided on 11/9/25, and Pneumococcal Conjugate (PCV 13) dated 11/5/15, was provided on 12/1/25, for PCV 20. The document showed the signature of the Resident 1; however, the document did not show if the updated VIS for the pneumococcal vaccination was provided and/or if the risks, benefits, and potential side effects of the pneumococcal vaccination were explained to Resident 1 and/or their representative. 2. Medical record review for Resident 8 was initiated on 1/29/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 11/20/25, showed Resident 8 had no capacity to understand choices and make healthcare decisions. Review of the facility document titled Resident Vaccine log (Flu/pneumococcal/COVID-19) dated 2025-26 did not show on the records if Resident 8 received pneumococcal and influenza vaccination. Review of Resident 8's Vaccine VIS (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Acknowledgement and Consent dated 11/20/25, under the section Vaccine information Sheet, did not show if the updated influenza and pneumococcal VIS were provided. Under the section date VIS was provided showed Resident 8 received influenza and pneumococcal vaccine; however, the document did not show the date when influenza and pneumococcal vaccination were. Further review of the document did not show if risks, benefits and potential side effects of influenza and pneumococcal vaccine were explained to the resident and or their representative. 3. Medical record review for Resident 27 was initiated on 1/29/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 4/1/25, showed Resident 27 had no capacity to understand choices and make health care decisions. Review of Resident 27's MDS assessment dated [DATE], showed Resident 27 had severe cognitive impairment. Review of the facility document titled Resident Vaccine log (Flu/pneumococcal/COVID-19) dated 2025-26, showed Resident 27 received influenza vaccine on 10/1/25. Review of Resident 27's Vaccine VIS Acknowledgement and Consent dated 9/4/25, showed the consent was signed by resident 27's representative; however, under the section Vaccine information Sheet, it did not show if the updated influenza VIS was provided. Further review of the document did not show if the risks, benefits, and potential side effects of the influenza vaccination were explained to the Resident 27 and or their representative before the administration of the influenza vaccination. 4. Medical record review for Resident 18 was initiated on 1/28/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 9/25/25, showed Resident 18 had no capacity to understand choices and make health care decisions. Review of Resident 18's MDS assessment dated [DATE], showed Resident 18 had memory problem and was dependent on the staff for his activities of daily living. Review of the facility document titled Resident Vaccine log (Flu/pneumococcal/COVID-19) dated 2025-26 showed Resident 18 declined the influenza and pneumococcal vaccination. Review of Resident 18's Vaccine VIS Acknowledgement and Consent dated 9/25/25, showed Resident 18's representative declined the influenza and pneumococcal vaccination for Resident 18. Further review of the document did not show if Resident 18's representative was provided with the education on risks, benefits, and potential side effects of the influenza and pneumococcal vaccination. 5. Medical record review for Resident 3 was initiated on 1/28/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 4/1/25, showed Resident 3 had no capacity to understand choices and make health care decisions. Review of the facility document titled Resident Vaccine log (Flu/pneumococcal/COVID-19) dated 2025-26 showed Resident 3 declined the influenza vaccine, and received the pneumococcal vaccine on 10/11/25. Review of Resident 3's Vaccine VIS Acknowledgement and Consent dated 10/10/25, did not show if Resident 3 or their representative received updated VIS for influenza and pneumococcal vaccination. Further review of the document did not show if Resident 3 and/or their representative were provided with the education on risks, benefits, and potential side effects of the influenza and pneumococcal vaccination. On 1/29/26 at 1139 hours, an interview and concurrent medical record review for Residents 1, 3, 8, 18 and 27 was conducted with the IP/DSD. The IP/DSD stated she provided Vaccine VIS Acknowledgement and Consent form before the administration of the vaccine. The IP/DSD acknowledged the Vaccine VIS Acknowledgement and Consent form did not have the updated vaccine information and did not include the risks, benefits, and potential side effects of the updated influenza and pneumococcal vaccination. When the IP/DSD was asked to show the VIS form she provided before the administration of the influenza and pneumococcal vaccination to the residents and before the resident and resident's representative could make informed decisions, the IP/DSD was not able to show. The IP/DSD stated she did not know what the VIS looked like. The IP/DSD verified the above findings and stated she was not able to find the documentation if the updated VIS for the pneumococcal vaccination was provided and/or if the risks, benefits, and potential side effects of the pneumococcal vaccine was explained to Resident 1 and/or their representative when Resident 1 received the pneumococcal vaccine in the facility on 12/1/25. The IP/DSD verified the facility was not able to show proof of the influenza and pneumococcal (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vaccination information to Resident 8's representative. The IP/DSD stated she should have provided the education regarding the risks, benefits, and potential side effects of the vaccination to the resident's representative for Resident 8 so they make an informed decision. The IP/DSD verified Resident 27 received the influenza vaccination on 10/1/25. The IP/DSD verified there was no documented evidence if Resident 27's representative was provided with the education on risks, benefits, and potential side effects of the influenza vaccination and/or updated VIS for the influenza vaccination. The IP/DSD verified Resident 18's representative declined the influenza and pneumococcal vaccination for Resident 18. The IP/DSD also verified there was no documented evidence if the risks, benefits, and potential side effects of the updated influenza and pneumococcal vaccination were explained to Resident 18's representative. The IP/DSD verified Resident 3's representative declined the influenza vaccination, consented to give pneumococcal vaccination on 10/10/25, and Resident 3 received the pneumococcal vaccination on 10/11/25. The IP/DSD verified there was no documented evidence if Resident 3's representative was provided with the education on the risks, benefits, and potential side effects and/or updated VIS for the influenza and pneumococcal vaccination. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the education on the risks and benefits of the COVID-19 vaccinations were reviewed with the resident and/or resident representative for three of three final sampled residents (Residents 1, 3 and 18) and two nonsampled residents (Residents 8 and 27) reviewed for immunization. * The facility failed to ensure the residents or their representatives wer provided education on the risk, benefits and potential side effects of COVID-19 vaccination before administration of the COVID-19 vaccination to Residents 1 and 3. * The facility failed to ensure the residents or their representative were provided education on the risk, benefits and potential side effects of COVID-19 vaccination when the resident's representative declined the COVID-19 vaccination for Residents 8, 27 and 18. These failures had the potential for the residents and/or their representatives not being informed of the COVID-19 vaccine, the benefits, risks and potential side effects of the COVID-19 vaccine to make an informed decision. Findings: Review of the facility's P&P titled COVID-19 Vaccination dated 10/2022 showed the facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 by offering the resident, staff members, and volunteer workers immunization to COVID-19. The resident medical record will include documentation that the resident and/or the resident's representative was provided education regarding benefits and potential side effects of immunization, that the resident receive or did not receive the immunization due to medical contraindication or refusal, administration and follow-up monitoring of the vaccine. 1. Medical record review for Resident 1 was initiated on 1/28/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 12/5/25, showed Resident 1 had the capacity to understand and make healthcare decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of Resident 1's Non-PRN Medication Notes for December 2025 showed Resident 1 received the Spikevax (COVID-19) vaccine. Review of Resident 1's Vaccine VIS Acknowledgement and Consent dated 12/5/25, showed Resident 1 would like to receive the COVID-19 vaccination. Further review of the document did not show if Resident 1 or their representative was provided education on the risk, benefits and potential side effects of the COVID-19 vaccination. 2. Medical record review for Resident 8 was initiated on 1/29/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's H&P examination dated 11/20/25, showed Resident 8 had no capacity to understand choices and make healthcare decisions. Review of Resident 8's Vaccine VIS Acknowledgement and Consent dated 11/20/25, showed Resident 8's representative declined the COVID-19 vaccine for Resident 8. Further review of the document did not show if Resident 8 or their representative was provided education on the risk, benefits and potential side effects of the COVID-19 vaccination. 3. Medical record review for Resident 27 was initiated on 1/29/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 4/1/25, showed Resident 27 had no capacity to understand choices and make health care decisions. Review of Resident 27's MDS assessment dated [DATE], showed Resident 27 had severe cognitive impairment. Review of Resident 27's Vaccine VIS Acknowledgement and Consent dated 9/4/25, showed Resident 27's representative declined the COVID-19 vaccination for Resident 27. Further review of the document did not show if Resident 27 or their representative was provided education on the risk, benefits and potential side effects of the COVID-19 vaccination. 4. Medical record review for Resident 18 was initiated on 1/28/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 9/25/25, showed Resident 18 had no capacity to understand choices and make health care decisions. Review of Resident 18's MDS assessment dated [DATE], showed Resident 18 had memory problems and was dependent on the facility staff for his activities of daily living. Review of Resident 18's Vaccine VIS (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Acknowledgement and Consent dated 9/25/25, showed Resident 18's representative declined the COVID-19 vaccination for Resident 18. Further review of the document did not show if Resident 18's representative was provided with education on the risk, benefits and potential side effects of the COVID-19 vaccination. 5. Medical record review for Resident 3 was initiated on 1/28/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 4/1/25, showed Resident 3 had no capacity to understand choices and make health care decisions. Review of the facility document titled Resident Vaccine log (Flu/pneumococcal/COVID-19) for the years 2025-2026, showed Resident 3 received the COVID-19 vaccination on 10/14/25. Review of Resident 3's Vaccine VIS Acknowledgement and Consent dated 10/10/25, did not show if Resident 3 or their representative received education on the risk, benefits and potential side effects of the COVID-19 vaccination. On 1/29/26 at 1139 hours, an interview and concurrent medical record review for Residents 1, 3, 8, 18 and 27 was conducted with the IP/DSD. The IP/DSD stated she provided the Vaccine VIS Acknowledgement and Consent form before the administration of the vaccine. The IP/DSD acknowledged the Vaccine VIS Acknowledgement and Consent form did not have the updated vaccine information and did not include the risks, benefits and potential side effects of the updated COVID-19 vaccination. When the IP/DSD was asked to show the VIS form she provided before the administration of the COVID-19 vaccination to the residents and before the resident and resident's representative could make informed decisions, the IP/DSD was not able to show the form. The IP/DSD verified the above findings and stated she was not able to find the documentation to show if the updated VIS for the COVID-19 vaccine was provided and/or if the risk, benefits and potential side effects of the COVID-19 vaccine was explained to Residents 1 and 3 and/or their representative when Resident 1 and 3 received the COVID-19 vaccine in the facility. The IP/DSD verified Residents 8, 27, and 18's representative declined the COVID-19 vaccination for Residents 8, 27 and 18. The IP/DSD also verified there was no documented evidence to show if the risk, benefits and potential side effects of the updated COVID-19 vaccination were explained to their representative. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the informed consent was obtained for the use of psychotropic medications (any drug prescribed to stabilize or improve mood, mental status, or behavior) for one of five final sampled residents reviewed for unnecessary medications (Resident 1). * The facility failed to ensure the informed consent was obtained from Resident 1 or their responsible party when the frequency of the trazodone (antidepressant) was changed. This failure posed the risk of Resident 1 and his responsible party to not be informed and understand the risks and benefits of the treatment and medications.Findings: Review of the facility's P&P titled Psychotropic Medication Informed Consent Guide, undated ,showed informed consent was required for all residents receiving psychotropic medications and updated when there is medication change. Under the section documentation standard, the P&P showed to document client's right to accept or refuse medication, explanation of the nature of the mental health condition and why the psychotropic medication was prescribed, type of medication prescribed, the specific name of the medication, and dose frequency, and administering route of medication prescribed. Medical record review for Resident 1 was initiated on 1/28/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 12/5/25, showed Resident 1 had the capacity to understand and make healthcare decisions. Review of Resident 1's MDS assessment dated [DATE], showed Resident 1 was cognitively intact. Review of Resident 1's Physician Order Sheet dated January 2026 showed an order dated 12/31/25, for trazodone 50 mg tablet, to give 25 mg via GT for depression as manifested by difficulty falling asleep at hours of sleep. Review of Resident 1's Acknowledgement of Psychoactive Medication Use, dated 12/5/25, showed the trazodone medication 25 mg tablet via enteral tube (GT) every hour of sleep as needed for depression as manifested by difficulty falling asleep. Further review of Resident 1's medical record failed to show if an informed consent was obtained when the trazodone medication was changed to routine at bed time. On 2/2/26 at 0850 hours, an interview and concurrent medical record review for Resident 1 was conducted with RN 6. RN 6 stated the hours of sleep in the physician's order meant at bed time. RN 6 verified the above findings and stated she was not able to find documented evidence if an informed consent was obtained from Resident 1 or their representative when the trazodone medication's frequency was changed to routine at bed time on 12/31/25. On 2/2/26 at 0941 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure a copy of the resident's advanced directive was available in their medical record for one of one final sampled resident (Resident 13) investigated for Advanced Directives. * The facility failed to obtain a copy of Resident 13's advance directive and place in the resident's medical record. This failure had the potential for the resident's wishes for medical care and choice of healthcare agent not being communicated effectively in the event the resident was unable to make her own medical decisions. Findings: Medical record review for Resident 13 was initiated on 1/28/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's H&P examination dated 9/2/25, showed the resident had the capacity to understand and make healthcare decisions. Review of Resident 13's POLST dated 9/3/25, showed the resident did not have an advanced directive (a legal document that outlines your preferences for medical treatment and appoints a healthcare agent to make decisions on your behalf if you become incapacitated and unable to communicate). Review of Resident 13's medical record failed to show an advanced directive. On 1/28/26 at 1205 hours, an interview was conducted with Resident 13. Resident 13 stated she had formulated an advanced directive.On 1/29/26 at 1508 hours, an interview was conducted with Resident 13's family member, Family Member 1, at Resident 13's bedside. Family Member 1 stated Resident 13 did have an advanced directive and stated she had it on her phone, and she pulled up Resident 13's advanced directive dated 1/20/24. Family Member 1 stated she was unsure if the facility asked her about an advanced directive, but she would have given them a copy if they asked her about it since it has been saved on her phone. On 1/29/26 at 1513 hours, an interview and concurrent medical record review for Resident 13 was conducted with the SSD. The SSD stated the process was to ask the resident or their responsible party on admission if they had an advanced directive. The SSD stated RN 1 was the staff who went over the advanced directive paperwork for Resident 13. On 1/29/26 at 1515 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 1. RN 1 stated her process was to talk to the resident or their family if a resident had formulated an advanced directive. RN 1 reviewed Resident 13's medical record and verified the POLST was wrong if the resident did have an advanced directive. RN 1 then went to Resident 13's bedside to speak with Family Member1, and verified the resident had an advanced directive.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the appropriate bed hold process was followed for one of one sampled resident (Resident 42) reviewed for bed hold. * Resident 42's bed hold was cancelled prior to the end of the seven-day bed hold. This failure resulted in Resident 42 not being allowed to return to the facility when Resident 42 was transferred to the acute care hospital. Findings: On 1/23/26, CDPH received a complaint regarding Resident 42's bed hold being cancelled prior to the end of the seven-day bed hold. Review of the facility's P&P titled SAU (Subacute Unit) Transfer, Discharge, Bed-hold Procedure reviewed 9/2025 showed at the time of transfer/discharge, the patient and family member or legal representative are given a written notice of the bed-hold policy that specifies the duration of the bed hold and readmission criteria after the bed-hold period ends. In addition, the policy showed the SAU allows a patient whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan to return to the SAU immediately upon the first availability of a bed in a semi-private room even if the patient has an outstanding Medicaid balance, if the patient requires the services provided by the SAU and is eligible for Medicaid nursing SAU services. Furthermore, the policy showed if the SAU determines a patient who was transferred with an expectation of returning to the SAU, cannot return to the SAU, the SAU complies with the requirements to notify the patient and the patient's representative of the transfer or discharge and the reasons for the move in writing and in language and manner they understand; the SAU sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman; the written notice of transfer/discharge includes: reason for transfer/discharge, effective date of transfer/discharge, location to which the patient is transferred/discharge, statement that the patient has the right to appeal the action to the state, including the name, address (mailing and email), and telephone number of the entity which resolves such requests and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; name, address, and telephone number of the state long term care ombudsman, and for patients with intellectual and developmental disabilities or related disabilities, mailing address and email address and telephone number of the agency responsible for protection and advocacy of developmentally disabled. On 1/28/2026 at 1544 hours, a telephone interview was conducted with Hospital Case Manager 1. Hospital Case Manager 1 stated their staff informed the facility on 1/18/26, that Resident 42 was ready to return to the facility. Hospital Case Manager 1 stated Resident 42 was transferred to the hospital on 1/12/26. Hospital Case Manager 1 stated the facility's Administrator told Hospital Case Manager 1 Resident 42 could not return to the facility unit where he previously resided and there was no available bed for Resident 42. Closed medical record review for Resident 42 was initiated on 1/28/26. Resident 42 was admitted to the facility on [DATE], and was transferred to the acute care hospital on 1/12/26. Review of Resident 42's Notice of Transfer/Discharge Form dated 1/12/26 showed Resident 42 was transferred to the acute care hospital, and the transfer or discharge was necessary for the resident's welfare and the needs cannot be met in the facility. Review of Resident 42's SAU Form-Notice of Bedhold dated 1/12/26, showed Resident 42 has left the SAU for a hospitalization or therapeutic leave on 1/12/26 , and elected to hold his bed from 1/12 to 1/18/26. Review of Resident 42's acute care hospital's progress notes dated 1/18/25, showed on 1/15/25, Resident 42's condition was stable and Resident 42's return to the facility could start on 1/16/26, if he continued to improve. Further review of the progress note showed Resident 42's condition was improving so on 1/17/25, Resident 42's plan to return to the facility could be started. Another progress note dated 1/18/25, showed Resident 42's condition remained stable and could return to the facility. On 1/29/2026 at 0841 hours, an interview was conducted with the Administrator. When asked about Resident 42 not being allowed to return to his room on 1/18/26, the (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated he was told on 1/14/26, by Hospital Discharge Coordinator 1, via telephone, Resident 42 would not be returning to the facility any time soon. The Administrator stated he then cancelled Resident 42's bed hold, discharged Resident 42 from his room, and gave Resident 42's room to another resident. The Administrator stated the facility's unit only had a total of 14 rooms which were covered by Resident 42's insurance. When asked when Resident 42 could return to one of the rooms covered by Resident 42's insurance, the Administrator stated Resident 42 was on a waiting list, waiting for a room to become available. On 1/30/2026 at 1546 hours, a follow up interview was conducted with the Administrator and the DON. When asked if the Administrator had further clarified with Discharge Coordinator 1 or any other hospital staff about what the statements meant regarding Resident 42 would not be returning to the facility any time soon and the resident would be in the hospital a few more days to be more accurate on a specific date Resident 42 would be returning to the facility, the Administrator stated, no. The Administrator stated he took the statements from Discharge Coordinator 1 to mean Resident 42 would not be returning. Therefore, on 1/14/26, the Administrator gave Resident 42's room to another resident. On 2/4/26 at 1130 hours, a telephone interview was conducted with Contracts Unit Chief 1. Contracts Unit Chief 1 stated the facility could hold Resident 42's room for two weeks, from the date of transfer to the acute care hospital, if Resident 42 was expected to return. When informed of the above findings, Contracts Unit Chief 1 acknowledged and stated the Administrator should not have cancelled Resident 42's bed hold.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident or resident's representative was provided with the required information when the resident was transferred and/or discharged for two of three sampled residents (Residents 39 and 42) reviewed for transfer and discharge. * The facility failed to ensure Resident 39 and/or their representative were notified of the transfer and reasons for the transfer in writing when the resident was discharged to an Assisted Living Facility. * The facility failed to provide facility's bed hold policy and notice of transfer when Resident 42 was transferred to the acute care hospital and was not permitted to readmit to the facility. These failures resulted in the interested parties not having the complete information related to the discharge and transfer process. In addition, this failure had the potential for the resident and/or their representative of not knowing about the appeals process and the circumstances of the resident's transfer/discharge should the resident and/or their representative believe the transfer or discharge was inappropriate or involuntary.Findings: Review of the Facility's P&P titled Transfer Discharge Bed-Hold Procedure dated 9/2025 showed the patient, if known, the family member, surrogate or legal representative, are notified at least 30 days prior to the transfer, unless the transfer is affected when.patient has not resided in the facility for 30 days. The Content of the Written Notice included the following: Reason for transfer/discharge; Effective date of transfer discharge; Location to which the patient is transferred discharged ; Statement that the patient has the right to appeal the action to the state; Name, address, and telephone number of the state long term care ombudsman; and, As applicable, mailing address and telephone number of the agency responsible for protection and advocacy of developmentally disabled or mentally ill individuals. Medical record review for Resident 39 was initiated on 1/30/26. Resident 39 was admitted to the facility on [DATE]. Review of Resident 39's H&P examination dated 10/10/25, showed Resident 39 had the capacity to understand choices and make health care decisions. Review of Resident 39's Physician Order Sheet showed a physician's order dated 11/11/25, for Discharge to an Assisted Living. Review of Resident 39' s Progress Notes dated 11/11/25 at 1629 hours, showed Resident 39 was transferred to an assisted living facility. Review of Resident 39's Notice of Transfer/discharge date d 11/11/25, showed transfer location as an assisted living facility and the reason for transfer was because Resident 39's health was improved (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sufficiently so that Resident 39 no longer required the services provided by the facility. Under the section for the resident or resident representative signature showed the notice was provided to the resident's representative via telephone and did not show a signature of the resident's representative. The Notice of Transfer/Discharge showed if you believe that the proposed transfer discharge is inappropriate in your case, and is involuntary, you have the right to appeal. The appeal can be filed in writing to, or by calling the following with provided phone number: DHCS office of administration hearing and appeals TDA/RTR unit. Stated Long term care ombudsman office. State agency for developmentally disabled State agency for mentally ill The Notice of Transfer Discharge further showed, If you intend to file an appeal of this transfer/discharge, it is important that you do so within 10 calendar days of being notified. The decision regarding an appeal will normally be made within 30 days from the date of Notice of Transfer/Discharge. The ability of the Department of Health to render a decision on the appeal, maybe jeopardized if the appeal is not submitted within 10 calendar days. Further review of Resident 39's medical record did not show if the Written Notice of Transfer/Discharge was provided in writing when Resident 39 was discharged to an assisted living facility on 11/11/25. On 1/30/26 at 1057 hours, an interview and concurrent medical record review for Resident 39 was conducted with RN 3. RN 3 verified Resident 39 was discharged to an assisted living on 11/11/25. RN 3 verified Resident 39's representative was informed of transfer discharge notice via telephone. RN 3 further stated she was not aware if the facility mailed the written Notice of Transfer/Discharge to the resident or their representative when the residents in the facility were transferred or discharged . RN 3 was not able to verify if the written notice of Transfer/Discharge was provided to Resident 39's representative when Resident 39 was transferred to an assisted living facility on 11/11/26. On 1/30/26 at 1145 hours, an interview was conducted with the Medical Records Director. The Medical Records Director stated she faxed the Notice of Transfer/Discharge to the Ombudsman; however, she did not mail the written notice of transfer/discharge if the resident or their representative was unable to sign at the time of the transfer or discharge. The Medical records Director verified she did not mail the written notice of Transfer/Discharge to Resident 39's representative when Resident 39 was discharged to an assisted living facility on 11/11/25. On 2/2/26 at 0941 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled SAU (Subacute Unit) Transfer, Discharge, Bed-hold Procedure reviewed 9/2025 showed at the time of transfer/discharge, the patient and family member or legal representative are given a written notice of the bed-hold policy that specifies the duration of the bed hold and readmission criteria after the bed-hold period ends. In addition, the policy showed the SAU allows a patient whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan to return to the SAU immediately upon the first availability of a bed in a semi-private room (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	even if the patient has an outstanding Medicaid balance, if the patient requires the services provided by the SAU and is eligible for Medicaid nursing SAU services. Furthermore, the policy showed if the SAU determines a patient who was transferred with an expectation of returning to the SAU, cannot return to the SAU, the SAU complies with the requirements to notify the patient and the patient's representative of the transfer or discharge and the reasons for the move in writing and in language and manner they understand; the SAU sends a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman; the written notice of transfer/discharge includes: reason for transfer/discharge, effective date of transfer/discharge, location to which the patient is transferred/discharge, statement that the patient has the right to appeal the action to the state, including the name, address (mailing and email), and telephone number of the entity which resolves such requests and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; name, address, and telephone number of the state long term care ombudsman, and for patients with intellectual and developmental disabilities or related disabilities, mailing address and email address and telephone number of the agency responsible for protection and advocacy of developmentally disabled. Closed medical record review for Resident was initiated on 1/23/26. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's Notice of Transfer/Discharge Form dated 1/12/26 showed Resident 42 was transferred to the acute care hospital, and the transfer or discharge was necessary for the resident's welfare and the needs cannot be met in the facility. Review of Resident 42's SAU Form-Notice of Bedhold dated 1/12/26, showed Resident 42 has left the SAU for a hospitalization or therapeutic leave on 1/12/26, and elected to hold his bed from 1/12 to 1/18/26. Review of Resident 42's Progress Notes dated 1/12/26, showed Resident 42's Family Member 2 was called to inform Resident 42 was transferred to the acute care hospital. Review of Resident 42's Notice of Transfer/Discharge with effective date of 1/12/26, showed on the line for Resident/Resident Representative Signature that Family Member 2 was informed via telephone regarding Resident 42's transfer to the acute care hospital. Further review of Resident 42's Notice of Transfer/Discharge showed the content of this notice included reason for the transfer to the acute care hospital and the appeal process in case the resident/resident representative believed the discharge was inappropriate or involuntary. On 1/30/26, at 1504 hours, a telephone interview was conducted with Family Member 2. When asked if she had received a copy of the Notice of Transfer/Discharge for Resident 42's transfer to the hospital on 1/12/26, Family Member 2 stated, no. When asked if she knew about the contents of the notice of Transfer/Discharge, Family Member 2 stated no. On 1/30/26, at 1533 hours, an interview was conducted with RN 3. When asked about providing Resident 42's Notice of Transfer/Discharge, RN 3 stated the notice was given to the medical records staff. When asked if a copy of Resident 42's Notice of Transfer/Discharge was mailed to Resident 42's Responsible Party, RN 3 stated the nursing staff did not mail the notices. On 1/30/26, at 1543 hours, an interview was conducted with the Medical Records Director. When asked if medical records staff had mailed the notice of transfer/discharge to Resident 42s (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Responsible Party, the Medical Records Director stated she did not mail a copy of the notice and she thought nursing staff mailed the copy of the notice of transfer/discharge to Resident 42's Responsible Party.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to develop detailed resident centered care plans for two of 12 final sampled residents (Residents 1 and 22).* The facility failed to ensure a care plan was developed to address the use of insulin (medication to lower blood sugar) for Residents 1 and 22.These failures posed the risk of not providing appropriate, consistent, and individualized care to these residents.Findings: Review of the facility's P&P titled Care Plans released 11/2022 showed a comprehensive care plan is developed consistent with the patients' conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetable to meet the patient's needs as identified in the patient's assessment or as identified in relation to the patient's response to the interventions or changes in the patient's condition, reflects the patient's needs and preferences and align with the patient cultural identity and if a history of trauma, describes the corresponding interventions for care in accordance with the professional standards of practice. The facility will provide or arrange these services by individuals who have the skills, experience, and knowledge to do particular task or activity in accordance with the patient's plan of care. 1. Medical record review for Resident 1 was initiated on 1/28/26. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 12/5/25, showed Resident 1 had the capacity to understand and make healthcare decisions. Review of Resident 1's Physician Order Sheet dated January 2026 showed the following orders: - Dated 12/31/25, for insulin glargine 100 units/ml subcutaneous solution (15 units) at hours of sleep (at bed time). - Dated 12/31/25, for insulin lispro 100 units/ml subcutaneous pen to administer subcutaneously, as follows: for glucose less than 70 or greater than 400 to notify physician. 71 to 150 mg/dl, to give 0 units of insulin; 151 to 200 mg/dl, to give 2 units of insulin; 201 to 250 mg/dl, to give 4 units of insulin; 251 to 300 mg/dl, to give 6 units of insulin; 301 to 350 mg/dl, to give 8 units of insulin; and, 351 to 400 mg/dl, to give 10 units of insulin for diabetes mellitus. Review of Resident 1's Care Plan dated 12/5/25 to 1/29/26 did not show a care plan problem was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developed to address the use of insulin. 2. Medical record review for Resident 22 was initiated on 1/28/26. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's H&P examination dated 11/28/25, showed Resident 22 had no capacity to understand choices and make health care decisions. Review of Resident 22's Physician Order Sheet dated January 2026 showed a physician's order dated 12/31/25, for insulin lispro 100 unit/ml subcutaneous (under skin) pen to administer 3 units subcutaneously every 6 hours. On 2/2/26 at 0850 hours, an interview and concurrent medical record review for Residents 1 and 22 was conducted with RN 6. RN 6 verified Residents 1 and 22 were receiving insulin. RN 6 verified there was no care plan problem initiated to address the use of insulin for both residents. RN 6 stated the insulin was identified as the interventions for diabetes; however, she was not able to find a care plan problem addressing the use insulin. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the individualized and ongoing activity program to meet the needs and interests for one of one final sampled resident (Resident 18) reviewed for activities. * The facility failed to provide documentation Resident 18 received meaningful activities from the facility for December 2025 and January 2026. This failure had the potential to affect the resident's psychosocial well-being.Findings: Review of the facility P&P titled Activity Programs dated 11/2022 showed the facility to provide based on the comprehensive assessment and care plan and the preference of each patient, an ongoing program to support patients in their choices of activities, both group and individual activities and independent activities, designed to provide each patient to have a meaningful life by supporting his/her domains of well-being. Activities are individualized and customized based on the patient previous life style (occupation, family, hobbies), preference and comfort. On 1/28 at 0930 hours, 1/29 at 0846 and 1415 hours, and on 1/30/26 at 0846 hours, Resident 18 was observed lying awake in bed and staring at the wall. The television on the right side of Resident 18's bed was turned off. Resident 18 was not observed to be engaged in any activities. Medical record review for Resident 18 was initiated on 1/28/26. Resident 18 was admitted to the facility on [DATE]. Review of Resident 18's H&P examination dated 9/25/25, showed Resident 18 had no capacity to understand choices and make health care decisions. Review of Resident 18's MDS dated [DATE], showed Resident 18 had memory problem and was dependent on the staff for his activities of daily living. Review of Resident 18's Activity/Therapeutic Recreation assessment dated [DATE], showed it was very important for Resident 18 to listen to the music. Further review of the Activity/Therapeutic Recreation Assessment showed Resident 18 enjoyed watching television and listening to the music. Review of Resident 18's Care Plan showed a care plan problem addressing Resident 18 as being dependent on staff for activities with the goal dated 4/8/26, showed Resident 18 will maintain involvement in cognitive sensory stimulation desired through next review date. The interventions included Resident 18 needed one to one bedside/in-room visits 3-5 times a week as tolerated, to assist Resident 18 in selection of relaxation activities such as music, massage, guide imagery, and water therapy. Further review of the care plan showed Resident 18 preferred soft music, reading daily chronicle, and CNN (news channel). Review of Resident 18's Individual Participation Record dated December 2025 and January 2026 failed to show if any activities was provided to Resident 18 in December 2025 and January 2026. Individual Participation Record for Resident 18 dated December 2025 and January 2026 had no entries. On 1/30/26 at 0931 hours, an interview and concurrent medical record review for Resident 18 was conducted with the Activity Director. The Activity Director stated she provided music, turned on the TV for Resident 18, and provided one to one sensory stimulation to Resident 18. When the Activity Director was asked if she could provide the documentation of the activities provided to Resident 18 for December 2025 and January 2026, the Activity Director was not able to show documentation. The Activity Director verified the above findings and stated there was no documented evidence if activity was provided to Resident 18 in December 2025 and January 2026. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one of four sampled residents (Resident 2) reviewed for pressure injuries received the care and services to heal the resident's pressure injuries. * Resident 2's special mattress was not functioning properly. In addition, there was no physician's order for the use of the special mattress. This failure posed the risk of delay in healing for Resident 2's pressure injuries. Findings: Medical record review for Resident 2 was initiated on 1/28/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 10/8/25, showed Resident 2's diagnoses included Stage IV pressure injuries to her sacrum and left hip. Further review of the H&P showed Resident 2 had the capacity to understand choices and make health care decisions. Review of Resident 2's January 2026 Physician Order Sheet dated 1/29/26, showed a a diagnosis of pressure ulcer of sacral region, Stage IV dated 10/7/25. Further review of the Physician Order Sheet failed to show a physician's order for the use of the special mattress. Review of Resident 2's Care Plan Report with a print date of 1/29/26, showed a care plan problem with an effective date of 10/7/25-present, for alteration in skin integrity related to admitted with left hip pressure injury Stage 4. The interventions included to provide pressure reducing mattress for skin management. On 1/28/2026 at 1038 hours, Resident 2 was observed in bed, sleeping. Resident 2's bed was observed to be an extra wide special mattress. To the left side of Resident 2's bed a display showed E410. The foot of the bed for Resident 2 showed a flashing light showing the upper right side of Resident 2's body. On 1/28/2026 at 1639 hours, Resident 2 was observed in bed, awake. Resident 2 was observed with her bed displaying E410 and the foot of the bed with the flashing light showing the upper right side of Resident 2's body, and a beeping sound coming from the foot of Resident 2's bed. When asked about Resident 2's bed, Resident 2 stated she had informed the facility staff about her feeling her mattress did not inflate or deflate. On 1/28/26 at 1645 hours, an observation and concurrent interview for Resident 2 was conducted with CNA 1. When asked about the code showing E410 to the side of Resident 2's bed and the flashing light at the foot of Resident 2's bed, CNA 1 was unable to state what the code meant. Per CNA 1, she did not notice the flashing light at the foot of Resident 2's bed. On 1/28/26, at 1655 hours, an observation and concurrent interview for Resident 2 was conducted with LVN 1. When asked about the error code to the side of Resident 2's bed and the flashing light at the foot of Resident 2's bed, LVN 1 verified the findings but stated she (LVN 1) did not notice the error code or the flashing light at the foot of Resident 2's bed. On 1/28/26, at 1700 hours, an observation and concurrent interview for Resident 2 was conducted with RN 5. RN 5 verified the above findings. RN 5 was observed pressing down on Resident 2's mattress and Resident 2 stated she said could not feel the mattress inflating or deflating. RN 5 verified the E410 to the side of Resident 2's mattress was an error code. RN 5 also verified Resident 2 did not have a physician's order for the use of special mattress.

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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 interview, medical record review, and facility P&P review, the facility failed to ensure one of one nonsampled resident (Resident 27) reviewed for limited range of motion received the appropriate treatment and services. * The RNA services and instructions for Resident 27 were not completed. This failure had the potential to result in the decline in Resident 27's range of motion which could lead to further deterioration in the resident's physical well- being.Findings: Review of the facility's P&P titled Guideline-Restorative Services dated 8/2025, showed restorative techs are hired , trained, and employed by the rehabilitation department. The restorative plan for each patient is developed through a collaborative effort between nursing and therapy. Once completed, the restorative plan of care is incorporated into nursing plan of care. Patient may receive services up to seven days a week. Patient placed in the restorative program may meet one or more of the criteria from the list which included patient who are at a very low level of function, requiring only basic exercise and/or transfer out of the bed to maintain current level of function. They may have poor rehabilitation potential but need regular follow-up and reassessment by the therapist. On 1/29/26 at 0834 hours, an interview with Family Member 3 for Resident 27 was conducted. Family member 3 stated Resident 27 had not received any therapy services currently. When Family Member 3 was asked if the facility provided exercises for Resident 27, Family Member 3 stated he had not seen the facility staff providing exercises for Resident 27. Medical record review for Resident 27 was initiated on 1/29/26. Resident 27 was admitted to the facility on [DATE]. Review of Resident 27's H&P examination dated 4/1/25, showed Resident 27 had no capacity to understand choices and make health care decisions. Review of Resident 27's MDS assessment dated [DATE], showed Resident 27 had severe cognitive impairment and had impairment in bilateral lower and upper extremities. Review of Resident 27's Physical Therapy Discharge Summary showed the date of services: 11/5-12/5/25, showed discharge recommendation for Resident 27 will continue to be seen by CNA/RNA for bed to wheelchair vice versa via Hoyer lift and PROM (Passive Range of Motion) on the bilateral lower extremities. Mother was aware of proper donning and doffing of right PRAFO (Pressure Relief Ankle Foot Orthosis) for positioning as tolerated with skin check. Review of Resident 27's Care Plan showed a current problem addressing Resident 27's self-performance deficit and limited physical mobility with related diagnoses included contracture on right and left hand. Interventions included transfer Resident 27 from bed to wheelchair and vice versa using a Hoyer lift, PROM on bilateral lower extremities, right ankle PRAFO boots to provide three times weekly, as needed starting 11/24/25. Review of Resident 27's Physician Telephone Order dated 12/8/25, showed an order to discontinue skilled physical therapy services and refer to CNA/RNA for bed to wheelchair transfer via Hoyer lift and PROM on bilateral extremities. Further review of the telephone order did not show an order for right PRAFO for positioning with skin check, and the frequency of how often the RNA services to be provided to Resident 27. On 1/30/26 at 1119 hours, an interview and concurrent medical record review for Resident 27 was conducted with RNA 1. RNA 1 stated she provided RNA services to Resident 27 three times a week. RNA 1 stated she transferred the resident from bed to the wheelchair and vice versa using a Hoyer lift, provided PROM on bilateral lower extremities, and also applied PRAFO boots. When RNA 1 was asked how long she kept the PRAFO boots on, she was not able to answer. When asked if she performed skin checks for the use of the PRAFO boots and documented, she was not able to answer. Review of the RNA services provided to Resident 27 dated December 2025 and January 2026 showed to provide transfer from bed to wheelchair and vice versa using a Hoyer lift, PROM on bilateral lower extremity, and right ankle PRAFO boots as needed. The above services were provided on 12/8, 12/9, 12/15/26, and on 1/6, 1/8, 1/13, 1/19, 1/20, 1/22, 1/23, 1/26 and 1/29/26. On 1/30/26 at 1337 hours, an interview and concurrent medical record review for Resident 27 was conducted with the Rehab Director. The Rehab (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director stated Resident 27 had quadriplegia (a medical condition involving partial or total loss of sensory and motor function in all four limbs and the torso, usually caused by injury or disease to the cervical spinal cord) and required continued RNA services to maintain current level of range of motion. The Rehab Director verified the PT discharge summary did not show the frequency of RNA services to be provided as to how often to transfer Resident 27 from bed to wheelchair and vice versa; and how often to provide PROM to bilateral extremities. In addition, the recommendation did not show how often to put the PRAFO boots on and for how long for Resident 27. The Rehab Director stated the facility practice was to provide RNA services to the residents three times a week; however, the PT recommendation should have specified the frequency based on Resident 27's needs. On 1/30/25 at 1452 hours, an interview and concurrent medical record review for Resident 27 was conducted with the DSD/IP. The DSD/IP verified the above findings and stated she transcribed the physician's therapy RNA recommendation and communicated to the RNA staff. The DSD/IP stated she should have clarified the PT recommendation with the rehab department and specified the frequency for transferring Resident 27 from bed to wheelchair and vice versa, PROM to bilateral extremities, and PRAFO boots. In addition, the DSD/IP stated she should have clarified the duration as to how long to keep PRAFO boots on. The DSD/IP verified there was no order for skin checks, and no documented evidence if skin checks related to the use of PRAFO boots were conducted for Resident 27. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the proper pain assessment, implementation of non pharmacological interventions, and appropriate pain medication administration per physicians' orders for two of five residents (Residents 7 and 13) reviewed for unnecessary medications. * Resident 7's admission pain assessment was incomplete. The resident did not have physicians' orders to appropriately address and treat the resident's pain level, and the facility failed to document and implement NPI for pain management. * Resident 13 did not have documented use of non pharmacological interventions for pain management. These failures had the potential to put the residents at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medications.Findings: Review of the facility's Subacute Unit (SAU) Procedure - Pain Management P&P reviewed May 2025 showed: - Upon admission, nursing will perform an initial pain assessment to include the residents' history of pain, past effective treatment including non pharmacological interventions and pharmacological interventions, characteristics and impact of their pain. - Provide non pharmacological interventions for pain management and/or medication as ordered by the physician. 1. Medical record review for Resident 7 was initiated on 1/28/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's admission Pain assessment dated [DATE], showed asked if pain was present, and showed 0. No, stop here. The rest of the pain assessment was blank. There were no other Pain Assessments in the resident's medical record. Review of Resident 7's Physician Order Sheet for January 2026 showed:- An order dated 12/31/25, for acetaminophen 650 mg (a pain medication) via GT every four hours PRN for pain, with no ordered pain parameters.- An order dated 12/31/25, for hydrocodone 5 mg - acetaminophen 325 mg (a opioid pain medication) via GT every four hours PRN for moderate pain (pain level of 4-6, on a pain scale from 0 for no pain and 10 being the worst pain). Review of Resident 7's MAR for January 2026 showed the resident received hydrocodone 5mg - acetaminophen 325 mg as needed for pain on the following dates and times:- On 1/1/26 at 1243 hours, for a pain level of 4;- On 1/2/26 at 1313 hours, for a pain level of 7, above the ordered pain level range of 4-6;- On 1/3/26 at 1635 hours, for a pain level of 8, above the ordered pain level range of 4-6;- On 1/11/26 at 2016 hours, for a pain level of 5;- On 1/12/26 at 1948 hours, for a pain level of 5;- On 1/13/26 at 1913 hours, for a pain level of 5;- On 1/25/26 at 1943 hours, for a pain level of 5; and- On 1/27/26 at 2304 hours, for a pain level of 4. Review of Resident 7's MAR also showed acetaminophen 650 mg was administered for pain on the following times:- On 1/3/26 at 0747 hours, for a pain level of 4; and- On 1/14/26 at 2024 hours, for a pain level of 3. There was no documentation to show non pharmacological interventions were attempted prior to the administration of the above pain medications. On 2/2/26 at 0937 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 5. RN 5 reviewed Resident 7's physician's orders and MAR, and stated the acetaminophen was usually administered for mild pain, and there should be pain parameters in the physician's order. RN 5 also verified the MAR showed the hydrocodone 5mg - acetaminophen 325 mg was administered for pain levels of 7 and 8, which were above the ordered parameters, and should have been clarified with the physician before the administration of the medications. RN 5 was unable to locate in the resident's medical record to show non pharmacological interventions were implemented prior to the administration of the pain medications. On 2/5/26 at 0807 hours, an interview and concurrent medical record review for Resident 7 was conducted with RN 3. RN 3 stated the initial pain assessments were completed on admission. RN 3 reviewed Resident 7's admission Pain assessment dated [DATE], and stated the resident did not have any pain at the time of the assessment, so the rest of the assessment did not need to be completed. RN 3 stated there were no other Pain Assessments in the resident's medical record. RN 3 reviewed Resident 7's medical record and verified there was no documentation to show non pharmacological interventions were implemented prior to PRN pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication use. On 2/5/26 at 0812 hours, an interview, medical record review, and concurrent facility document review for Resident 7 was conducted with the DON. The DON verified Resident 7's admission Pain Assessment failed to address the resident's history of pain, past effective treatment including non pharmacological interventions and pharmacological interventions, and characteristics and impact of their pain, which would help in developing an effective and patient centered pain management plan. 2. Medical record review for Resident 13 was initiated on 1/28/26. Resident 13 was admitted to the facility on [DATE]. Review of Resident 13's Physician Order Sheet for January 2026 showed the following physician's orders:- An order dated 12/31/25, for acetaminophen 650 mg, via GT PRN every four hours for mild pain (1-4 pain level)- An order dated 12/31/25, for hydrocodone 5 mg - acetaminophen 325 mg, give one tablet via GT every six hours routinely for pain management - An order dated 12/31/25, for hydrocodone 5 mg - acetaminophen 325 mg, give two tablets via GT PRN every six hours for moderate to severe pain (4-10 pain level). Review of Resident 13's MAR for January 2026 showed the resident received acetaminophen 650 mg PRN for mild pain on the following dates and times:- On 1/7/26 at 0831 hours, for a pain level of 4;- On 1/11/26 at 0900 hours, for a pain level of 4; and- On 1/28/26 at 1447 hours, for a pain level of 4.Review of Resident 13's MAR also showed in addition to the resident's routine hydrocodone 5mg - acetaminophen 325 mg pain medication, two tablets were administered PRN for pain on the following dates and times:- On 1/6/26 at 1037 hours, for a pain level of 8;- On 1/8/26 at 0233 hours, for a pain level of 8;- On 1/8/26 at 1000 hours, for a pain level of 8;- On 1/16/26 at 1004 hours, for a pain level of 5;- On 1/25/26 at 0853 hours, for a pain level of 8; and- On 1/27/26 at 1009 hours, for a pain level of 8. There was no documentation to show non pharmacological interventions were attempted prior to the administration of the above pain medications. On 2/5/26 at 0807 hours, an interview and concurrent medical record review for Resident 13 was conducted with RN 3. RN 3 reviewed Resident 13's medical record and verified there was no documentation to show non pharmacological interventions were implemented prior to routine and PRN pain medication use.

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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 observation, interview, medical record review, and facility P&P review, the facility failed to ensure the nursing staff were competent. * The facility failed to ensure LVN 2 diluted the crushed medications before administering them via GT for one of two nurses observed for GT medication administration. * The facility failed to ensure the IP/DSD was aware about the VIS (Vaccination Information Sheet) and the need to provide the residents and and their representative with the education on risks, benefits, and potential side effects from the influenza, pneumococcal, and COVID-19 vaccinations. These failures had the potential for a partial dose being administered or the tube becoming clogged. In addition, the failures had the potential for the residents and/or their representatives in the facility of not being informed of the updated influenza, pneumococcal, and COVID-19 vaccinations, the benefits, risks, and potential side effects of the influenza, pneumococcal, and COVID-19 vaccinations to make an informed decision.Findings: Review of the facility's P&P titled Medication Administration through an Enteral Tube revised 11/15/24, showed the medications should be crushed individually into a fine powder and reconstituted with 10-15 ml of water, and mixed well. Insert a medication syringe into the tube port and pour each medication into the syringe, flushing with at least 15 ml of water after each medication. On 1/29/26 at 0821 hours, a medication observation and concurrent interview for Resident 13 was conducted with LVN 2. LVN 2 was observed crushing the medications and vitamins/minerals into nine separate medication cups, undiluted, and poured them separately into the medication syringe attached to the resident's GT, and flushed with water in between. LVN 2 stated Resident 13 was not on a fluid restriction, and her usual practice was to pour the crushed medications undiluted into the med syringe when administering GT medications. On 1/29/26 at 0905 hours, an interview was conducted with the DON. The DON stated the crushed medications should be diluted before pouring the into the medication syringe for administration. 2. Review of the facility's Vaccine VIS Acknowledgement and Consent for Resident 27 dated 9/24/25, showed as required under the national childhood vaccine injury act (42 U.S.C section 300 a.a.26), all health care providers in the United states who administer any vaccine containing diphtheria, tetanus, pertussis, measles, mumps, rubella, polio, hepatitis B, Hemophilus influenza type B(hib), trivalent influenza, pneumococcal conjugate, or Varicella (chickenpox) vaccine shall, prior to administration of each dose of the vaccine, provide a copy to keep off the relevant current addition vaccine information materials that have been produced by the Center for Disease Control and prevention. Any adult to whom the provider intends to administer such vaccine. If a person is under the legal age of an adult, relevant VIS shall be provided to the individual legal representative. Vaccine VIS Acknowledgement and Consent showed a list of Vaccine Information Sheet (VIS) which included: Inactivate influenza vaccine, edition 8/15/2019. Pneumococcal Conjugate (PCV 13), 11/5/2015. Pneumococcal Polysaccharide Vaccine (PPSV23), 4/24/15. COVID-19 vaccine/Brand. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Vaccine VIS Acknowledgement and Consent did not show the risks, benefits, and potential side effects of updated influenza, pneumococcal and COVID-19 vaccinations. On 1/29/26 at 1139 hours, an interview and facility document review was conducted with the IP/DSD. The IP/DSD stated she provided the influenza, pneumococcal, and COVID-19 vaccinations to all the residents in the facility. The IP/DSD stated she provided the Vaccine VIS Acknowledgement and Consent to the residents and residents' representative before the administration of the vaccination, or before the resident or resident representative made informed decisions. When the IP/DSD was asked if she could show the updated VIS she provided the residents and their representatives before administering the influenza, pneumococcal, and COVID-19 vaccinations, as directed by the Vaccine VIS Acknowledgement and Consent form that she used, the IP/DSD pointed to the form Vaccine VIS Acknowledgement and Consent again. The IP/DSD was again asked to show the actual VIS for influenza, pneumococcal, and COVID-19 vaccine, The IP/DSD stated she did not know how the actual VIS looked like. The IP/DSD verified the Vaccine VIS Acknowledgement and Consent did not show the risks, benefits, and potential side effects of the updated influenza, pneumococcal, and COVID-19 vaccinations, and as directed by the form she was to provide individual VIS for each influenza, pneumococcal, and COVID-19 vaccinations. The IP/DSD stated she did not provide the updated VIS to the residents who received the vaccinations and who declined the vaccinations in the facility. On 2/2/26 at 0941 hours, an interview was conducted with DON. The DON was informed and acknowledged the above findings. Cross reference F883 and F887

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to follow-up on the Pharmacist Consultant's Medication Regimen Review (MRR) recommendations for one of five residents investigated for Unnecessary Medications. * The facility failed to provide an in-service education to the staff per the Pharmacist Consultant's Report recommendation to remind the staff of administering/holding medications within the ordered parameters. This failure resulted in the continued deficient practice of midodrine (medication to treat low blood pressure) being administered to the residents (Residents 7 and 13) outside of the ordered parameters. Findings:Review of the facility's Medication Regimen Review (MRR) P&P revised 6/1/24, showed the consultant pharmacist will conduct monthly MRR and make recommendations, which will be provided to the facility, and the facility will act upon the recommendations. Review of the facility's MRR binder, showed a Pharmacist's Consultation Report for 12/3-4/25. The report showed Resident 13's midodrine was documented as administered outside the ordered parameters, with a physician's order to hold for a SBP (systolic blood pressure) greater than 130. The medication was documented as administered on 12/2/25 at 0900 hours, with a SBP of 138. The pharmacist's recommendation showed to remind staff of the importance of administering/holding medications within the ordered parameters. The page showed other residents' recommendations, with a line through it and done handwritten next to the recommendations. Resident 13's midodrine recommendation did not have a line through it or done written next to it. During the Unnecessary Medication review, the above deficient practice was noted to continue for two residents (Residents 7 and 13) with orders for midodrine:a. Medical record review for Resident 13 was initiated on 1/28/26. Resident 13 was admitted on [DATE]. Review of Resident 13's MAR for January 2026 showed an order for midodrine 10 mg to be administered via GT every 12 hours, and to hold for a SBP greater than 130. The MAR showed on 1/28/26 at 0900 hours, the midodrine medication was administered with a SBP of 139 (above the ordered hold parameter for a SBP greater than 130). b. Medical record review for Resident 7 was initiated on 1/28/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's MAR for January 2026 showed the resident had an order for midodrine 5mg to be administered via GT every eight hours, and to hold for a SBP greater than 130. The MAR showed the midodrine was documented as administered with an SBP greater than 130 on the following dates:-On 1/12/26 at 2000 hours, with an SBP 134;-On 1/13/26 at 0600 hours, with an SBP 150; -On 1/13/26 at 2200 hours, with an SBP 143;-On 1/14/26 at 0600 hours, with an SBP 152;-On 1/17/26 at 0600 hours, with an SBP 134; and-On 1/30/26 at 0600 hours, with an SBP 133. On 2/2/26 at 0937 hours, RN 5 reviewed Residents 7 and 13's MARs for January 2026 and verified the midodrine medication was documented as administered outside of the ordered parameters. On 2/2/26 at 1019 hours, an interview and concurrent record review was conducted with the DSD. The DSD stated she did not review the MRR reports, and has not done any staff training based on any report findings. The DSD reviewed Resident 13's pharmacist's recommendation from December 2025 and stated she was not aware of the concerns and had she known she would have in-serviced the nursing staff per the pharmacist's recommendations. On 2/2/27 at 1057 hours, an interview and concurrent record review was conducted with he DON. The DON stated he and two other RN's reviewed and acted upon the pharmacist's MRR. The DON reviewed Resident 13's recommendations regarding the midodrine medication being administered outside of the ordered parameter, and stated he did not see that in the report, and would have done a one on one in-service with the nurse who administered the medication.

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	555859	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kindred Hospital Brea D/P Snf	875 N Brea Blvd Brea, CA 92821

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 32%. Two of five licensed staff (LVN 2 and RN 4) were found to have made errors during the medication administration observations.* LVN 2 failed to administer the complete dose for four of Resident 13's crushed medications when medication residues were observed in the medication pouches. * RN 4 failed to administer the complete dose for four of Resident 18's crushed medications when the medication residues were observed in the medication pouches and cups. These failures had the potential to negatively affect the residents' health.Findings: 1. On 1/29/26 at 0821 hours, a medication administration observation for Resident 13 was conducted with LVN 2. LVN 2 was observed crushing the following medications and then transferring them to the individual medication cups to be administered via GT:-hydrocodone 5 mg - acetaminophen 325 mg tablet (controlled medication for pain relief)-cetirizine (medication to relieve allergies) 10 mg tablet-clonazepam (medication to treat anxiety) 0.5 mg tablet-Vitamin B-12 (supplement)500 mcg tablet-fluoxetine (medication to treat depression) 10 mg tablet-folic acid (supplement) 1 mg tablet-midodrine (medication to treat low blood pressure) 10 mg tablet-oxybutynin (medication to treat overactive bladder) 5 mg tablet, one half tablet-Vitamin C (supplement) 500 mg tablet-daily multivitamin (supplement) one tabletAfter crushing and administering the above medications, four (clonazepam, oxybutynin, cetirizine, and Vitamin B-12) had medication residuals in the medication pouches and/or medication cups after administration. LVN 2 verified the findings. 2. On 1/29/26 at 0914 hours, a medication administration observation was conducted for Resident 18 with RN 4. RN 4 was observed crushing the following medications and then transferring them to the individual medication cups to be administered via GT:-Vitamin D3 (supplement) 1000 u tablet-docusate sodium (medication to treat constipation) 100 mg tablet-furosemide (medication to reduce extra fluids in the body) 20 mg tablet-Vitamin C (supplement) 500 mg tablet-docusate sodium 50 mg/sennosides (medication to treat constipation) 8.6 mgOf the five crushed medications administered, four (Vitamin D3, docusate sodium, furosemide, and Vitamin C) had medication residuals in the pill pouches. In addition, after administering the medications, the medication cups with furosemide, Vitamin C, and Vitamin D3 also had medication residual in the cups. RN 4 verified the findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure complete and accurate medical records for one of five final sampled residents reviewed for unnecessary medications (Resident 7), and one of three final sampled residents reviewed for pressure injuries (Resident 4). * Resident 7's documented pain level for each shift did not show the resident's highest pain level for the shift on multiple shifts.* Resident 3's Stage 4 pressure injury was incorrectly documented on their weekly assessment as a DTI (Deep Tissue Injury). These failures resulted in inaccurate medical records for Residents 4 and 7. Findings: 1. Medical record review for Resident 7 was initiated on 1/28/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's Physician Order Sheet for January 2026 showed a physician's order dated 12/11/25, to monitor for pain every shift on a scale of 0 to 10 (0 being no pain, and 10 being the worst pain). a. Review of Resident 7's TAR for December 2025 showed the resident had no pain or signs of pain for all shifts in December. Review of Resident 7's MAR for December 2025 showed the resident received hydrocodone 5mg - acetaminophen 325 mg (a controlled pain medication) as needed for pain on the following dates and times:-On 12/13/25 at 1648 hours, for a pain level of 7;-On 12/16/25 at 1944 hours, for a pain level of 6;-On 12/29/25 at 1517 hours, for a pain level of 5;-On 12/30/25 at 0130 hours, for a pain level of 6; and-On 12/31/25 at 0810 hours, for a pain level of 6. b. Review of Resident 7's TAR for January 2026 showed on 1/2/26, day shift (07-1900 hours), a pain level of two. The TAR showed the resident had no pain or signs of pain for rest of the shifts in January. Review of Resident 7's MAR for January 2026, showed the resident received hydrocodone 5mg - acetaminophen 325 mg as needed for pain on the following dates and times:-On 1/1/26 at 1243 hours, for a pain level of 4;-On 1/2/26 at 1313 hours, for a pain level of 7;-On 1/3/26 at 1635 hours, for a pain level of 8;-On 1/11/26 at 2016 hours, for a pain level of 5;-On 1/12/26 at 1948 hours, for a pain level of 5;-On 1/13/26 at 1913 hours, for a pain level of 5;-On 1/25/26 at 1943 hours, for a pain level of 5; and-On 1/27/26 at 2304 hours, for a pain level of 4. On 2/5/26 at 0901 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON reviewed Resident 7's MARs and TARs and verified the above findings. The DON stated the resident's highest level of pain was not documented for the shift. However, the DON thought the level of pain at the time the nurse did their assessment was appropriate, instead of documenting the resident's highest level of pain for the shift. On 2/5/26 at 0951 hours, a follow up interview was conducted with the DON. The DON stated he spoke with their educator and she informed him the highest level of pain for the shift should be documented. 2. Medical record review for Resident 4 was initiated on 1/28/26. Resident 4 was admitted to the facility on [DATE]. Review of Resident 4's MDS assessment dated [DATE], showed the resident had six Stage 4 pressure injuries with four that were present on admission. The MDS also showed the resident had no DTI's. Review of Resident 4's Wound Assessment initiated 9/16/25, showed the resident had a DTI to the left lateral head. The Assessment showed on 12/10/25, the wound was a DTI. On 1/30/26 at 1024 hours, an interview and concurrent record review for Resident 4 was conducted with the MDS Coordinator. The MDS Coordinator stated Resident 4 had four Stage 4 pressure injuries present on admission, and two facility acquired Stage 4 pressure injuries. The two facility acquired pressure injuries included one Stage 3 that was upstaged to a Stage 4, and the other was a left lateral head DTI that was later staged at a Stage 4. The MDS Coordinator verified the resident's left lateral head Wound Assessment form showed on 12/20/25, the wound was a DTI; however, on 10/8/25, it was staged at a Stage 4, and then back to a DTI on 10/29/25. The MDS Coordinator stated once a wound was a Stage 4, it cannot go back down to a DTI or a lower stage, which was why the MDS Coordinator coded the pressure injury correctly in the MDS as a facility acquired Stage 4. On 1/30/26 at 1126 hours, an interview and concurrent medical record review for Resident 4 was conducted with LVN 1. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 1 stated she was one of the treatment nurses for Resident 4. LVN 1 stated a pressure injury will always be classified as the highest level it was staged at. For example, a Stage 4 will always be a stage 4, until it was healed. LVN 1 verified Resident 4's DTI was an unstageable wound, but once it became a Stage 4 on 10/8/25, it should have continued to be documented as a Stage 4 until it healed.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to maintain the essential equipment in a clean, sanitary, and safe operating condition for two of two sinks (Sinks 1 and 2) inspected. * The facility failed to ensure Sink 1 was working properly. * The facility failed to ensure Sink 2 had no missing knobs on the faucet. These failures resulted in the essential equipment not in operating condition and not to function in the way it was intended, which could expose the residents to unsafe practices.Findings: Review of the facility's Patients Diet List dated 1/28/26, showed a total of 13 out of 36 residents received food prepared in the facility's kitchen. On 1/28/26 at 0750 hours, a tour of the facility's kitchen and concurrent interview was conducted with Dietary Manager 1. When asked about the dishwashing area, Dietary Manager 1 stated Sink 1 was not working. In addition, Sink 2's faucet was observed with missing faucet knobs. Dietary Manager 1 verified the findings. On 1/28/26 at 0817 hours, an interview was conducted with the Engineering Manager. When asked about Sinks 1 and 2, the Engineering Manager stated he had work orders in place for both sinks. Review of the facility's work orders for Sinks 1 and 2 showed the work order was dated 1/6/26, and the work order was to replace the faucets for the kitchen sinks. The work order status showed awaiting approval. On 01/29/2026 1612 hours, a follow up interview was conducted with the Engineering Director. When asked how long Sinks 1 and 2 had been in disrepair, the Engineering Director stated since 1/6/26. When asked why Sinks 1 and 2 had not been replaced, the Engineering Director stated he was waiting for the order confirmation to be approved by the facility. On 1/30/26 at 1315 hours, an interview was conducted with the Administrator and RD 2. The Administrator and RD 2 were informed of the above findings.