STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555865	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Healthcare Center	4515 Huntington Drive South Los Angeles, CA 90032

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen. This deficient practice had the potential to result in harmful bacterial growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 94 of 94 residents who received food from the kitchen. Findings:During an observation on 12/1/2025 at 8:15 a.m., in the kitchen, in the presence of the Dietary Supervisor (DS), the following findings were observed:a. The handwashing sink did not have hot water.b. The handwashing sink was clogged. c. The surface of the can opener was blackened and covered with black stains and dried residue.d. The area surrounding the can opener blade and gear were stained with dark, hardened food debris. e. The air-drying area for the food services equipment such as water pinchers, plates, cutting boards, cups and spoons was dusty and unsanitary. f. A large piece of raw beef was not fully frozen and was leaking blood onto a box stored directly underneath it in the freezer. During a subsequent interview on 12/1/2025 at 8:20 a.m., with the DS, the DS stated the handwashing sink did not have hot water and was clogged which prevented staff from performing proper hand hygiene and increased the risk of food contamination. The DS stated unclean kitchen equipment and food service equipment kept under unsanitary conditions created a risk of re-contamination. The DS stated it was important for the kitchen sink to be operational and the food contact surfaces to remain clean and sanitary. The DS stated the raw beef should have been stored separately, and fully frozen to prevent leakage and contamination of other food items or food contact surfaces. The DS stated these failures had the potential of increased risk of foodborne illness due to cross-contamination and improper hand hygiene. During a concurrent observation and interview on 12/2/2025 at 11:55 a.m., in the kitchen, during a tray line observation, with the DS, multiple meal service plates were observed to have brownish-yellowish dried food particles. The plates were still wet. The DS stated unclean and wet plates indicated they had not been properly washed, rinsed, or air-dried prior to being stored for use. The DS stated staff are expected to follow proper dishwashing procedures, including complete removal of the food debris and allowing the items to air-dry thoroughly to prevent bacterial growth, The DS stated improper cleaning and sanitizing of the food service plates had a serious risk of foodborne illness. During a review of the facility's policy and procedure (P&P) titled Infection Control in Dietary and Kitchen Areas, revised 9/20/2025, the P&P indicated the facility was committed to maintaining strict infection prevention and control practices in all dietary and kitchen operations to minimize the risk of foodborne illness, cross-contamination, and the spread of infectious diseases within the facility. The P&P indicated the facility was to ensure a safe, sanitary environment for food preparation, handling, storage and services. During a review of the facility's P&P titled Food storage and Safety, revised 9/29/2025, the P&P indicated the facility was to store all food in a safe, sanitary, and temperature- controlled environment to prevent contamination, and foodborne illness. The P&P indicated raw meats must be stored on the lower shelf to prevent cross-contamination. During a review of the facility's P&P titled Kitchen Equipment Use, Cleaning, and Maintenance, revised 9/29/2025, the P&P indicated the facility was to ensure all kitchen equipment was cleaned and sanitized daily, or after each use.

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

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's personal inventory list was completed when staff did not obtain the resident's signature and did not document a valid reason for the missing signature for one of six sampled residents (Resident 3). This resulted in an incomplete inventory record and had the potential to affect the facility's ability to account for Resident 3's belongings.Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 3's diagnoses included peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), hypertension (high blood pressure), and diabetes (poor blood sugar control). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 10/16/2025, the MDS indicated Resident 3's cognitive skills (ability to think and reason) for daily decision making were moderately impaired. The MDS indicated Resident 3 required supervision or touching assistance for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 3's History and Physical (H&P), dated 8/18/2025, the H&P indicated Resident 3 had the capacity to understand and make decisions. During a concurrent observation and interview on 12/3/2025 at 9:00 a.m., in the hallway, observed Resident 3 yell at staff and accuse the staff of lying and stealing her belongings. Resident 3 stated she was missing three purses and several pairs of underwear. During a concurrent interview and record review on 12/3/2025 at 9:50 a.m. with the Assistant Director of Nursing (ADON), Resident 3's Inventory Sheet, dated 8/18/2025, was reviewed. The Inventory Sheet was signed by a Certified Nursing Assistant (CNA) and the ADON. The space designated for Resident 3's signature was blank. The space for the reason the resident was unable to sign was blank. There was no other supplemental documentation that indicated the reason why Resident 3 did not sign the inventory sheet. The ADON stated the process to complete a resident's personal inventory documentation was to have the CNA itemize each item with the resident, have the resident or the representative party (RP) sign the form to confirm each item, and have the registered nurse sign the sheet as confirmation of its completion. The ADON stated the form lacked Resident 3's signature and the reason why Resident 3 did not sign the form. During an interview on 12/3/2025 at 11:00 a.m. with the Social Services Director (SSD), the SSD stated the normal process for completing the inventory sheet was to have the CNA or the admitting nurse confirm each personal item with the resident. The SSD stated it was the nursing staff's responsibility to obtain the signature of the resident or the RP to confirm that each item was accurately listed. The SSD stated that if the nursing staff were unable to obtain the resident's or the RP's signature, it was the responsibility of the nursing staff to make her aware so that she could follow up. The SSD stated the Inventory Sheet was incomplete because it lacked Resident 3's signature. The SSD stated she was not made aware that the form was incomplete. The SSD stated it was important the Inventory Sheet was completed to ensure each item was accounted for, especially upon discharge, and to protect the resident's right to possess personal belongings within the facility. During a review of the facility's Policy and Procedure (P&P) titled, Inventory-Resident Belonging, revised 9/29/2025, the P&P indicated the facility was to maintain complete and current inventory of each resident's personal items from admission through discharge. The P&P indicated the designated nursing staff would perform an inventory with the resident or RP.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete accurate Minimum Data Set (MDS) assessments for four of 21 sampled residents (Residents 91, 61, 70 and 20) when failing to: 1. Ensure an accurate assessment of Resident 91's hearing and vision impairments.2. Ensure an accurate assessment of Resident 61 and 70's oral/dental status.3. Ensure an accurate assessment of Resident 20's hearing impairment. This failure had the potential to delay the development or the revision of care plan interventions for communication and sensory deficits for Resident 91 and 20, and dental status for Residents 61 and 70.Findings: 1. During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was initially admitted to the facility on [DATE]. Resident 91's diagnoses included history of falling, functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and hypertensive heart disease (high blood pressure). During a review of Resident 91's Minimum Data Set (MDS, a resident assessment tool), dated 8/26/2025, and 11/26/2025, the MDS indicated Resident 91's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 91 required supervision or touching assistance for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 91's hearing was adequate (no difficulty in normal conversation, social interaction, listening to the television). The MDS indicated Resident 91's vision was adequate (sees fine detail, such as regular print in newspapers or books). During a review of Resident 91's Baseline Care plan, dated 3/29/2025, the Care Plan indicated Resident 91 had visual deficits. During a review of Resident 91's Eye Exam, dated 10/22/2025, the Eye Exam indicated Resident 91 had a history of decreased vision, difficulty watching television, eating and recognition. The Eye Exam also indicted Resident 91 was diagnosed with dense cataracts (an eye disorder that forms when the lens of the eye becomes cloudy due to age-related changes that can cause blurry vision, difficulty seeing in low light, and double vision), optic pallor (whitening of the optic disc and indicates reduced blood flow or nerve fiber loss, signaling potential damage to this critical visual pathway) and glaucoma suspect (high pressure inside the eye that damages the optic nerve and can result in permanent vision loss). During a review of Resident 91's Social Services Quarterly Note, dated 11/21/2025, the note indicated Resident 91 was hard of hearing and had decreased vision that affected her ability to engage in communication and ability to recognize staff. During a concurrent observation and interview on 12/1/2025 at 8:00 a.m. with Resident 91, in Resident 91's room, observed Resident 91 with an opaque, white film over both eyes. Resident 91 stared at the wall and failed to make direct eye contact. Resident 91 stated she could not hear because her ears did not work well and to speak louder into her right ear. During a concurrent observation and interview on 12/2/2025 at 2:45 p.m. with Certified Nursing (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA) 2, Resident 91 was observed in the hallway. CNA 2 approached Resident 91's right side, leaned close to the resident's ear and asked Resident 91 if she had hearing aids. Resident 91 did not respond. CNA 2 repeated the question a second time. Resident 91 did not respond to verbal cues when CNA 2 spoke to the resident's left side. CNA 2 stated Resident 91 was hard of hearing and had poor vision. CNA 2 stated Resident 91 could identify an individual's location based on their silhouette or by determining where she heard the individual's voice. During an interview on 12/2/2025 at 3:00 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated for six months, she had known Resident 91 to have visual and moderate hearing impairments. During a concurrent interview and record review on 12/2/2025 at 4:11p.m. with the MDS Nurse (MDSN), the MDS RAI (Resident Assessment Instrument Manual) Version 3.0 (a manual that helps nursing home staff in gathering definitive information on a resident's strengths and needs, used in care plan development), dated 10/2025, was reviewed. The Manual indicated the MDSN was to observe the resident during verbal interactions throughout the day, consult direct care staff, and review the medical record to assess hearing. The Manual also indicated the MDSN was to ask caregivers and, or direct-care staff over all shifts about usual vision patterns. The Manual also indicated to ask the resident to look at regular-size print in a book or newspaper, and ask the resident to read aloud, starting with larger headlines and ending with the finest, smallest print to assess vision. The MDSN stated she assessed Resident 91's hearing, by asking Resident 91 one question and waiting for an appropriate response. The MDSN stated she did not observe Resident 91's verbal interactions throughout the day, nor consult other direct care staff. The MDSN stated if she had observed different observations and interviewed the staff, she would have been able to perform a more accurate assessment of Resident 91's hearing and the latest MDS submission was not accurate. The MDSN stated she assessed Resident 91's vision by asking Resident 91 whether she could read MDSN's name badge. The MDSN stated she was issued a standardized vision testing tool but did not use the tool at the time of the assessment. The MDSN stated there were different classifications of regular, fine and large print and a standardized vision tool would have enabled her to conduct a more accurate assessment of Resident 91's vision and the latest MDS submission was not accurate. The MDSN stated the inaccurate assessments led to an inaccurate clinical assessment of Resident 91 submitted to Centers for Medicare & Medicaid Services (CMS) and placed Resident 91 at risk for delayed implementation of care plan interventions. 2. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61's cognition was severely impaired. The MDS indicated Resident 61 required supervision assistance from staff for ADLs. The MDS indicated Resident 61 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 12/1/2025 at 8:01 a.m., in Resident 61's room, observed Resident 61 eating breakfast. Resident 61 stated it was hard to chew the food because he did not have his teeth. 3. During a review of Resident 70's admission Record, the admission Record indicated Resident 70 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 70's diagnoses (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included dysphagia, dementia, and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 70's cognition was impaired. The MDS indicated Resident 70 required supervision assistance from staff for ADLs. The MDS indicated Resident 70 was assessed as not having any oral and/or dental issues. During a concurrent observation and interview on 12/3/2025 at 8:20 a.m., with the MDSN, in Resident 70's room, Resident 70 was observed sitting on a chair. The MDSN stated Resident 70 did not have her upper and bottom teeth. The MDSN stated Resident 70 did not have her natural teeth. The MDSN stated Resident 70 did not have her natural teeth and the MDS assessment should be coded correctly to reflect Resident 70's dental status. During a concurrent interview and record review on 12/3/2025 at 8:35 a.m., with the MDSN, Resident 61's MDS, dated [DATE] and Resident 70's MDS, dated [DATE], section oral/dental status were reviewed. The MDS indicated Residents 61 and 70 were assessed as not having any oral and/or dental issues. The MDSN stated Resident 60's and 70's MDS oral/dental status assessment was coded incorrectly as it did not reflect the residents' actual oral and/or dental status. The MDSN stated that because Resident 60 and 70 did not have their natural teeth, the MDS should have been coded to reflect that both residents were edentulous (toothless). The MDSN stated accuracy of the MDS assessment was important not only for outcome measures and quality indicators, but also for developing and individualizing the care plan based on the resident's actual needs. The MDSN stated inaccuracy of the MDS assessment had the potential to negatively impact the care provided, lead to inappropriate care planning, and not meeting the residents' needs and services. 4. During a review of Resident 20's admission Record, dated 12/4/2025, the admission Record indicated Resident 20 was admitted to the facility on [DATE]. Resident 20's diagnoses included unspecified hearing loss to the left and right ear (loss of hearing in both ears), dementia (a progressive state of decline in mental abilities), quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury), and encephalopathy (any disease, damage, or disorder that affects the brain's function). During a review of Resident 20's History and Physical (H&P), dated 6/3/2025, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20's cognition was moderately impaired. The MDS indicated Resident 20 had adequate hearing. The MDS indicated Resident 20 required supervision (helper provides verbal cues and/or touching/steadying as the resident completes activity) for eating and moderate assistance (helper does less than half the effort) with toileting, bathing, oral, and personal hygiene. The MDS indicated Resident 20 required a wheelchair for mobility. During a concurrent observation and interview on 12/3/2025, at 1:58 p.m., with CNA 3 and Resident 20, observed Resident 20 seated on a wheelchair while CNA 3 assisted the resident with dressing. Resident 20 was called by name. The resident did not respond. CNA 3 stated Resident 20 was hard of hearing and would not be able to hear anyone unless the person was positioned very close to her ear. During a concurrent interview and record review on 12/3/2025, at 2:34 p.m., with LVN 2, Resident 20's MDS dated [DATE] was reviewed. The MDS indicated Resident 20's hearing was adequate. LVN 2 stated he was aware of Resident 20's hearing impairment. LVN 2 stated the MDSN was responsible (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for the MDS coding. LVN 2 stated the MDS was incorrect because Resident 20 had a hearing impairment and staff had to speak very close to the resident's ear for her to hear what was being said. During an interview on 12/4/2025, at 1:36 p.m., with the Director of Nursing (DON), the DON stated if Resident 20 had a diagnosis of hearing impairment, then the MDS should have reflected the hearing loss. The DON stated the nursing staff did not know the MDS process and required additional education. The DON stated that the nursing staff's lack of understanding of the MDS process made it more difficult to know the needs of the residents and holistically provide the resident care. During a review of the facility's Policy and Procedure (P&P) titled, MDS Assessment and Submission, revised 9/29/2025, the P&P indicated the facility was to ensure timely, accurate, and comprehensive completion and submission of the Minimum Data Set (MDS) assessments in compliance with Centers for Medicare & Medicaid Services (CMS) regulations, including the RAI User's Manual and 42 CFR 483.20.

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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 observation, interview, and record review, the facility failed to develop an individualized resident centered care plan for six of 18 sampled residents (Resident 91, Resident 20, Resident 42, Resident 55, Resident 61, and Resident 70) when: 1. Staff failed to develop a care plan addressing Residents 91 and 20's hearing impairment.2. Staff failed to develop a care plan addressing Resident 42 and 55's diagnosis of dementia (a progressive state of decline in mental abilities). 3. Staff failed to develop a care plan addressing Resident 61 and 70's missing natural teeth. These deficient practices had the potential for Residents 91, 20, 42, 55, 61, and 70 to not receive required appropriate care.Findings: 1. During a review of Resident 91's admission Record, the admission Record indicated Resident 91 was initially admitted to the facility on [DATE]. Resident 91's diagnoses included history of falling, functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and hypertensive heart disease (high blood pressure). During a review of Resident 91's Minimum Data Set (MDS, a resident assessment tool) dated 11/26/2025, the MDS indicated Resident 91's hearing and vision were adequate. The MDS indicated Resident 91's cognitive skills (ability to think and reason) for daily decision making were severely impaired. The MDS indicated Resident 91 required supervision or touching assistance for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 91's Social Services Quarterly Note, dated 11/21/2025, the note indicated Resident 91 was hard of hearing, which affected her ability to engage in communication. During an interview on 12/1/2025 at 8:00 a.m. with Resident 91, in Resident 91's room, Resident 91 stated she could not hear because her ears did not work well. Resident 91 asked to speak louder into her right ear. During a concurrent observation and interview on 12/2/2025 at 2:45 p.m. with Certified Nursing Assistant (CNA) 2, Resident 91 was observed in the hallway. CNA 2 approached Resident 91's right side, leaned close to the resident's ear and asked Resident 91 if she had any hearing aids. Resident 91 did not respond. CNA 2 repeated the question a second time. Resident 91 did not respond to verbal cues when CNA 2 spoke to the left side. CNA 2 stated Resident 91 was hard of hearing. During an interview on 12/2/2025 at 3:00 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 91 had hearing impairments. During a concurrent interview and record review on 12/3/2025 at 2:40 p.m. with LVN 1, all of Resident 91's Care Plans, dated in 2025, were reviewed. There were no care plans addressing Resident 91's hearing impairment or loss. LVN 1 stated it was important that Resident 91 had a care plan for her hearing loss so that staff would know how to care for and perform ALDs with Resident 91. 2. During a review of Resident 20's admission Record, the admission Record indicated Resident 20 was admitted to the facility on [DATE]. Resident 20's diagnoses included unspecified hearing loss to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the left and right ear (loss of hearing in both ears), dementia (a progressive state of decline in mental abilities), quadriplegia (paralysis from the neck down, including legs and arms, usually due to a spinal cord injury), and encephalopathy (any disease, damage, or disorder that affects the brain's function). During a review of Resident 20's History and Physical (H&P), dated 6/3/2025, the H&P indicated Resident 20 did not have the capacity to understand and make decisions. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20's cognition was moderately impaired. The MDS indicated Resident 20 required supervision (helper provides verbal cues and/or touching/steadying as the resident completes activity) for eating and moderate assistance (helper does less than half the effort) with toileting, bathing, oral, and personal hygiene. The MDS indicated Resident 20 required a wheelchair for mobility. During a review of Resident 20's Order Summary Report, dated 12/4/2025, the Order Summary Report indicated Resident 20 had an active order dated 6/5/2024 for an ear, nose, and throat consultation (ENT – an evaluation of the ears, nose, or throat by a specialist) as needed. During a review of Resident 20's medical record, the medical record indicated there was no care plan initiated for addressing Resident 20's hearing impairment. During a concurrent observation and interview on 12/3/2025, at 1:58 p.m., with Certified Nursing Assistant (CNA) 3 and Resident 20, observed Resident 20 seated on a wheelchair while CNA 3 assisted her with dressing. Resident 20 was called by name. The resident did not respond. CNA 3 stated Resident 20 was hard of hearing and would not be able to hear anyone unless the person was positioned very close to her ear. During a concurrent interview and record review on 12/3/2025, at 2:34 p.m., with Licensed Vocational Nurse (LVN) 2, Resident 20's care plans were reviewed. LVN 2 stated he knew Resident 20 well and he was aware of Resident 20's hearing impairment. LVN 2 stated the MDS nurse (MDSN) was responsible for initiating care plans upon admission. LVN 2 stated LVNs could also initiate, and revise care plans as needed. LVN 2 stated Resident 20 did not have a care plan addressing her hearing impairment. LVN 2 stated the staff knew when speaking to Resident 20 they must get close to her ear for her to hear what was being said. LVN 2 stated a care plan should have been initiated for Resident 20's hearing loss once it was determined she had a hearing impairment. LVN 2 stated the care plan guided the resident's care in the best way. LVN 2 stated a care plan for Resident 20's hearing impairment would have provided interventions on how to appropriately approach and communicate with the resident. LVN 2 stated not having a care plan for Resident 20's hearing impairment could affect the resident's communication and quality of life. During an interview on 12/4/2025, at 1:36 p.m., with the Director of Nursing (DON), the DON stated if Resident 20 had a diagnosis of hearing loss and staff stated the resident could not hear, then a care plan should have been initiated. The DON stated moving forward the nursing staff should initiate a care plan for anyone with potential hearing loss, especially older residents. The DON stated the nursing staff were relying too much on the consultant to do the care plans. The DON stated the nursing staff should be responsible for the care plans. The DON stated the licensed nursing staff needed more training in initiating care plans because she had been doing the care plans to make it easier on the nursing staff. The DON admitted she was helping the nurses so much they did not know how to use the care plans. The DON stated this created a problem because she could not be there all the time to see changes in the residents, and changes in the residents' condition could get missed (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because she did not provide direct care. The DON stated not having a care plan made it more difficult to know the needs of the residents and holistically provide the resident care. 3. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 42's diagnoses included dementia, diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 42's H&P dated 3/1/2025, the H&P indicated Resident 42 did not have the capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42's cognition was impaired. The MDS indicated Resident 42 required supervision assistance from staff for ADL's. During a concurrent interview and record review on 12/3/2025 at 8:06 a, m., with the MDS Nurse (MDSN), Resident 42's medical record was reviewed. The medical record indicated there was no care plan developed addressing Resident 42's diagnosis of dementia. The MDSN stated Residents 42 should have a care plan for dementia with interventions to ensure the continuity of care and to guide nurses on how to provide proper care for Residents 42 to improve outcome. 4. During a review of Resident 55's admission Record, the admission Record indicated Resident 55 was admitted to the facility on [DATE]. Resident 55's diagnoses included dementia. During a review of Resident 55's H&P dated 3/1/2025, the H&P indicated Resident 55 did not have the capacity to understand and make decisions. During a review of Resident 55's MDS, dated [DATE], the MDS indicated Resident 55's cognition was impaired. The MDS indicated Resident 55 required supervision assistance from staff for ADLs. During a concurrent interview and record review on 12/3/2025 at 8:06 a, m., with the MDS Nurse (MDSN), Resident 55's medical record was reviewed. The medical record indicated there was no care plan developed addressing Resident 55's diagnosis of dementia. The MDSN stated Resident 55 should have a care plan for dementia with interventions to ensure the continuity of care and guide nurses on how to provide proper care for Resident 55 to improve outcome. 5. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included dysphagia (difficulty swallowing), dementia, and major depression disorder. During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61's cognition was severely impaired. The MDS indicated Resident 61 required supervision assistance from staff for ADLs. During a concurrent observation and interview on 12/1/2025 at 8:01 a.m., in Resident 61's room, observed Resident 61 eating breakfast. Resident 61 stated it was hard to chew the food because he did not have teeth. During a concurrent interview and record review on 12/3/2025 at 8:30 a.m., with the MDSN, Resident (continued on next page)

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	555865	A. Building B. Wing	12/04/2025

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	61's current care plans were reviewed. There was no care plan addressing Resident 61's missing teeth. The MDSN stated a care plan was a tool to communicate and summarize the problem, the goal, and interventions to ensure the residents would receive proper care. 6. During a review of Resident 70's admission Record, the admission Record indicated Resident 70 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 70's diagnoses included dysphagia, dementia, and muscle wasting (weakening, shrinking, and loss of muscle). During a review of Resident 70's MDS, dated [DATE], the MDS indicated Resident 60's cognition was impaired. The MDS indicated Resident 70 required supervision assistance from staff for ADLs. During a concurrent observation and interview on 12/3/2025 at 8:20 a.m., in Resident 70's room, with the MDSN, Resident 70 was observed sitting on the chair. The MDSN stated Resident 70 did not have her upper and bottom teeth. The MDSN stated Resident 70 did not have her natural teeth. During a concurrent interview and record review on 12/3/2025 at 8:30 a.m., with the MDSN, Resident 70's current care plans were reviewed. There was no care plan addressing Resident 70's missing teeth. The MDSN stated a care plan was a tool to communicate and summarize the problem, the goal, and interventions to ensure the residents would receive proper care. During a review of the facility's policy and procedures (P&P) titled Comprehensive Person-Centered Care Planning, dated 9/29/2025, the P&P indicated the facility would develop and implement a comprehensive, person-centered care plan for each resident based on and interdisciplinary assessment of physical, mental, and psychological needs. The P&P indicated the care plan will include measurable objectives, timeframes, specific interventions.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure good grooming and personal hygiene for two of six sampled residents (Resident 61 and Resident 5) by failing to provide routine fingernail and toenail care. This failure had the potential to result in a negative impact on Residents 61 and 5's quality of life and self-esteem and had the potential for the development of infections. Findings:a. During a review of Resident 61's admission Record, the admission Record indicated Resident 61 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 61's diagnoses included dysphagia (difficulty swallowing), dementia (a progressive state of decline in mental abilities), and major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool), dated 6/28/2025, the MDS indicated Resident 61's cognition (ability to think and process information) was severely impaired. The MDS indicated Resident 61 required supervision from staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During an observation on 12/1/2025 at 10:00 a.m., in Resident 61's room, observed Resident 61's fingernails and toenails. Resident 61's fingernails had black substance underneath all ten fingernails. Resident 61's toenails were long, irregular in shape, and curled over the tip of the toes. During a concurrent observation and interview on 12/1/2025 at 10:03 a.m., with Certified Nursing Assistant (CNA) 1, in Resident 61's room, observed Resident 61 with a black substance underneath his fingernails. CNA 1 stated Resident 61's nails were dirty and required cleaning and trimming. CNA 1 stated nail care was one of the CNA's duties. CNA 1 stated the CNAs were responsible for clipping, trimming, and cleaning the resident's nails. CNA 1 stated residents' nails should be monitored daily to ensure the nails are clean and neat. CNA 1 stated that sometimes the residents scratch their skin and if they scratch themselves hard enough, they could create an open wound. CNA 1 stated if a resident had dirty fingernails and scratched themselves, that increased their risk of infection. CNA 1 stated having dirty fingernails was not sanitary because the resident will use their hands to hold their utensils when eating and any bacteria could transfer into their body. CNA 1 stated having dirty fingernails was not sanitary to other residents because if Resident 61 were to touch objects that other residents also touched, the bacteria under the Resident 61's fingernails could transfer to the object and then to the other residents. b. During a review of Resident 5's admission Record, the admission Record indicated Resident 5 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 5's diagnoses included cellulitis (a skin infection that causes swelling and redness), major depression disorder, and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognition was intact. The MDS indicated Resident 5 required supervision from staff for ADLs. During a concurrent observation and interview on 12/1/2025 at 10:16 a.m., with Resident 5, in Resident 5's room, observed Resident 5 with black substance undeath all ten fingernails. Resident 5 stated, No one has helped me clean or cut my nails yet.During an interview on 12/2/2025 at 10:10 a.m., with the Infection Preventionist (IP), the IP stated nail care should be assessed daily. The IP stated residents who required assistance with cleaning or trimming their nails should be assisted by the CNAs or licensed nurses. The IP stated fingernails were a source of bacteria, and that dirty or untrimmed nails could contribute to the spread of infection, especially among residents who may not be able to maintain their own hygiene. The IP stated routine nail care was an essential part of both personal hygiene and infection control. During a review of the facility's policy and procedure (P&P) titled Nail Care- Fingernails and Toenails, revised 9/29/2025, the P&P indicated the facility staff would perform fingernail and toenail care, such as cleaning and trimming as part of residents' daily grooming. The P&P indicated nail care will be performed by staff to promote resident hygiene, comfort, and dignity (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while preventing potential complications such as infections, skin breakdown, and pain related to poor nail care.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate clinical records for one of five sampled resident (Resident 72) after a change in condition. This failure resulted in incomplete and missing documentation regarding Resident 72's clinical status and had the potential to affect the resident's continuity of care.Findings:During a review of Resident 72's admission Record, the admission Record indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 72's diagnoses included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (loss of memory, thinking, reasoning, and judgment), tachycardia (fast heart rate), hypertension (HTN - high blood pressure), pneumonia (infection in the lungs), hyperlipidemia (high fat levels in the blood), age-related physical disability (physical limitations related to aging), unspecified fall (a fall with no specific cause documented), and gastric ulcer (an open sore on the lining of the stomach). During a review of Resident 72's Minimum Data Set (MDS - a resident assessment tool), dated 11/12/2025, the MDS indicated Resident 72's cognitive skills for daily decision making were moderately impaired (ability to think and reason). The MDS indicated Resident 72 had short term memory problems. The MDS indicated Resident 72 was dependent (helper does all the effort) on staff for eating, toileting, bathing, dressing, oral and personal hygiene. During a review of Resident 72's History and Physical (H&P), dated 11/20/2025, the H&P indicated Resident 72 had fluctuating capacity to understand and make decisions. The H&P indicated Resident 72 developed a fever (an abnormally high body temperature), increased agitation (restlessness or irritability), and aggressive behavior (actions such as resisting care) after a fall at the facility. The H&P indicated Resident 72's mental status deteriorated. The H&P indicated Resident 72 was transferred to a general acute care hospital (GACH) for further evaluation and was discharged back to the facility on [DATE]. During an observation on 12/1/2025 at 9:56 a.m., in Resident 72's room, observed Resident 72 lying in bed. Oxygen was infusing via a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) at 4 liters per minute (lpm). Resident 72 was lethargic (very tired, slow to respond, or difficult to wake up) and had shallow breathing. During a review of Resident 72's Nursing Progress Notes, dated 9/13/2025 through 11/12/2025, the progress notes indicated Resident 72 was being monitored for a fall. The progress notes did not indicate the date of the fall, the circumstances of the fall, or the resident's assessment immediately following the fall. During a review of Resident 72's Nursing Progress Notes, dated 11/18/2025 through 11/30/2025, the progress notes indicated licensed nurses documented Resident 72's antibiotic administration, monitoring, and the resident's condition. The Nursing Progress Notes did not indicate documentation regarding Resident 72's change in condition or any clinical concerns. During a review of the Nursing Progress Note dated 12/1/2025 at 6:10 p.m., the progress note indicated staff from a hospice (care focused on comfort for residents who are nearing the end of life) evaluated Resident 72 for hospice services. The progress notes did not indicate the reason the hospice referral was made and did not indicate the resident's condition leading to the hospice evaluation. During a review of Resident 72's Nursing Progress Note dated 12/2/2025 at 9 p.m., the progress note indicated Resident 72 was transitioning and had irregular breathing. The progress note did not indicate the resident's decline prior to the transition, did not indicate what assessments were completed, and did not indicate communication with the physician regarding the resident's worsening condition. During a review of Resident 72's Nursing Progress Note dated 12/3/2025 at 3:06 a.m., the progress note indicated Resident 72 was observed with irregular breathing throughout the night and was confirmed deceased by the Registered Nurse (RN) at 2 a.m. The progress notes further indicated the physician was notified. The progress note did not indicate Resident 72's condition leading up to her death and did not indicate what assessments were completed. The progress note did indicate any (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clinical concerns or changes before the resident was confirmed deceased . During an interview on 12/3/2025 at 8:18 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated on 12/3/2025, Resident 72 did not eat breakfast. CNA 4 stated Resident 72 was placed on hospice and was now NPO (no food or drink by mouth). During a concurrent interview and record review on 12/4/2025 at 8:29 a.m., with Licensed Vocational Nurse (LVN) 3, Resident 72's medical record, including Nursing Progress Notes dated 11/8/2025 through 12/3/2025 and Situation, Background, Assessment, Recommendation (SBAR - a communication tool used by healthcare workers when there is a change of condition among residents) dated 11/8/2025 was reviewed. LVN 3 stated he was unable to locate documentation in the nursing progress notes reflecting Resident 72's fall on 11/8/2025. LVN 3 stated the circumstances of the fall or the resident's status following the fall were not included in the progress notes. LVN 3 stated there were several entries but those entries did not indicate details of Resident 72's fall, the completed assessment, or any physician communication. LVN 3 stated the SBAR indicated Resident 72's physician and family were notified however, the SBAR was marked in progress and unsigned which prevented it from being viewed during the record review. LVN 3 stated he was unable to determine from the progress notes how Resident 72 progressed from the fall on 11/8/2025 to the hospital transfer on 11/12/2025 or why the hospitalization occurred four days after the fall. LVN 3 stated there was no documentation describing how Resident 72 declined following her return to the facility. LVN 3 stated he could not locate documentation reflecting communication with Resident 72's physician regarding the resident's decline, the rationale for the hospice referral, or the resident's condition prior to death. LVN 3 acknowledged the nursing progress notes were not complete. During a concurrent interview and record review on 12/4/2025 at 11:04 a.m., with the Assistant Director of Nursing (ADON), Resident 72's Nursing Progress Notes dated 11/8/2025 through 12/3/2025, SBAR Communication Form dated 11/8/2025, and the Fall Incident Report dated 11/8/2025 were reviewed. The ADON stated Resident 72 fell on [DATE] when she slipped down from her wheelchair. The ADON stated she was responsible for completing the resident's assessment and the incident report after the fall. The ADON stated she completed the body assessment, pain assessment, post-fall assessment, physician notification, family notification, and the investigation. The ADON stated all related documentation, including the fall details, the investigation, witness statements, the SBAR communication form, and the IDT documentation, were kept in the incident report binder in the Director of Nursing's (DON) office and were not placed in the nursing progress notes or elsewhere in the medical record. The ADON stated Resident 72 was transferred to a GACH on 11/12/2025 and returned on 11/18/2025 with pneumonia. The ADON stated she initiated antibiotic therapy and documented the resident's monitoring during and after the antibiotic course, which reflected the resident was stable. The ADON stated she did not document any assessments or change of condition after the antibiotic monitoring ended. The ADON stated she spoke with the family regarding the resident's decline and the plan for hospice but did not chart the resident's decline or the hospice discussion. The ADON acknowledged she did not document communication with the physician or the resident's worsening condition. The ADON stated, Legally, I do not have to document the resident's decline. I don't have to document anything after the antibiotic monitoring. The ADON stated, I do admit, I did not document on the resident for four days. During an interview and record review on 12/4/2025 at 12:00 p.m. with the Medical Records Director (MRD), Resident 72's SBAR Communication Forms dated 11/8/2025, 12/2/2025 and 12/3/2025 were reviewed. The MRD stated the SBAR Communication Forms in the electronic health record (EHR) were marked in progress and were not signed. The MRD stated the SBAR Communication Forms should have been completed and signed. The MRD acknowledged the incomplete status prevented the forms from being viewable in the EHR. During a concurrent interview and record review on 12/4/2025 at 1:36 p.m. with the DON, Resident 72's SBAR Communication Forms dated 11/8/2025, 12/2/2025 and 12/3/2025 were reviewed. The SBAR communication forms were marked in progress and unsigned in the system. The DON stated Resident 72 was transferred to the GACH after the resident's family reported the resident (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in pain. The DON stated the facility notified Resident 72's physician based on the family's concern. The DON stated the resident declined while at the hospital and returned to the facility with additional issues and continued to decline after readmission. The DON stated staff had been communicating with Resident 72's family regarding the resident's decline and stated the resident was being monitored. The DON stated nurses should have documented what was occurring with Resident 72 and stated documentation was important because staff performed the work and it should have been recorded. The DON stated documentation helped address issues affecting the resident and stated if staff did not document or address what was occurring, the resident would not receive the care they needed. The DON also reviewed Resident 72's EHR as displayed during the interview and stated she could see why it appeared the facility was withholding documentation. During a review of the facility's policy and procedure (P&P) titled Nursing Documentation, last updated 9/29/2025, the P&P indicated nursing documentation was required to be accurate, timely, complete, and legally compliant. The P&P indicated documentation must reflect assessments, interventions, resident responses, and clinical decision-making. The P&P indicated staff were required to document in real time or as soon as possible after care was provided and ensure entries were clear, concise, and legible. The P&P indicated incident and change-of-condition documentation was required to include the event, the resident's response, the assessment performed, physician notification, family notification, interventions, and the outcome, and indicated corresponding forms such as incident reports and post-fall evaluations must be completed as required.