STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555892	A. Building B. Wing	05/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Care Center	2108 Stillman Selma, CA 93662

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews and review of facility documents, the facility failed to ensure food was stored, prepared and distributed in accordance with professional standards for food service safety when:1. Leftover previously cooked rice was not monitored for cooling;2. One sanitation solution in a red bucket was not the appropriate concentration when the Food Service Worker (FSW 2) sanitized the food preparation counter; and3. The can opener was dirty with a thick black substance on the blade. This had the potential for the growth of microorganisms which can lead to food borne illness for the 31 residents admitted to the facility1. During an observation, in the kitchen, in the reach-in refrigerator, on 5/19/26 at approximately 10:38 a.m., there was a container of cooked rice dated 5/18/26 with a use by date of 5/21/26 that was 43 degrees Fahrenheit (F). During an observation with concurrent interview with the Certified Dietary Manager (CDM) on 5/19/2026 at 2:43 p.m., CDM confirmed the rice in the reach-in refrigerator and stated the cook on the 18th should have cooled it down and wrote it down on the log. CDM showed the surveyor the cooling log and confirmed the log was blank and stated nothing has been recorded for this month. During a review of the facility document titled Food and Nutrition: 2-Stage Cooling Temperature log, undated, indicated food must be cooled from 140 degrees F to 70 degrees F within the first two hours, then from 70 degrees F to 41 degrees F within the next four hours. 2. During an observation and concurrent interview on 5/19/26 at 11:17 a.m., Food service Worker 2 (FSW 2) wiped down the food preparation counter. Surveyor asked FSW 2 to check the concentration of the sanitation bucket. FSW 2 checked the concentration of the sanitizer in the bucket and it was 0 parts per million (ppm). FSW 2 stated that she filled up the bucket 30 minutes ago and was not sure why it was not the proper concentration. FSW 2 filled up the sanitation bucket again and tested the concentration and it was 200 ppm. During a review of the sanitizer bucket log, dated May 2026, showed on 5/19/26 at 11:00 a.m. it was 200 ppm. The log showed the appropriate concentration was 200 to 400 ppm. 3. During a joint observation and concurrent interview with the Certified Dietary Manager (CDM) on 5/19/26 at 9:05 a.m., the can opener had a thick black substance on the blade. The CDM acknowledged the black substance on the blade and stated it was very dirty. The CDM stated it should be cleaned after each use. During an interview with the Dietary Manager (DM) on 5/20/26 at 9:20 a.m., DM stated when they looked at their cleaning log the can opener was not listed on it and they plan to include that piece of equipment on it now. DM stated staff have been in-serviced to clean the can opener after each use. During a review of the of facility weekly cleaning schedule dated 5/18/26, did not show can opener. During a review of the facility policy and procedures titled Sanitation Inspection dated 2026, indicated as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. The facility did not provide a policy or procedure regarding food service equipment that needs to be cleaned. During a review of the United States Food and Drug Food Code, dated 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, indicated (a) equipment food-contact surfaces and utensils shall be clean to sight and touch. And c) nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.

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

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to promote and implement an antibiotic (ATB) stewardship and surveillance program (ATBS-designed to reduce unnecessary use of antibiotics and to limit the spread of antibiotic resistance in bacteria) for the use of antibiotics when the Infection Preventionist (IP) did not ensure the antibiotic surveillance log (chronological record used to continuous monitor antibiotic use) was complete and accurate to identify, track, and monitor resident antibiotic use. This failure had the potential to result in the administration of unnecessary and inappropriate antibiotic use, as well as inaccurate monitoring of antibiotic use which could lead to antibiotic-resistant organisms and inaccurate data monitoring and reporting. During a concurrent interview and record review on 5/21/26 at 3:45 p.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated she started as IP in August 2025 and shared the IP position with the Minimum Data Set Coordinator (MDSC). The DSD/IP stated included in her duty and responsibility as IP was monitoring infections in the facility and keeping track of logs. The DSD/IP reviewed the antibiotic (powerful, life-saving medicines used to treat bacterial infections) surveillance log and stated she did not have a record of the urine analysis (urine test) culture and sensitivity results (C&S-two-part lab procedure used to identify the exact cause of an infection and find the best medication to cure it) of residents who were ordered antibiotics for urinary bladder infection (UTI- bladder infection). The DSD/IP stated she did not have access to (name of company) laboratory to print the results. The DSD/IP stated she was not sure if the antibiotic ordered for residents was appropriate not knowing whether the bacteria was susceptible (vulnerable) or resistant to the medication. The DSD/IP stated she was not sure why the result was needed; residents were already ordered antibiotic medications. The DSD/IP stated she was trying to do her job the best way she can. During an interview on 5/22/26 at 9:25 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated resident's primary doctor usually orders urine test with C&S for residents with signs of bladder infections before ordering antibiotics. LVN 2 stated some primary doctor orders antibiotics before knowing the result of the urine test. LVN 2 stated it was the responsibility of the IP to update the primary doctor of the result of urine test including C&S once completed. LVN 2 stated all licensed nurses have access to the lab results and was not sure why the DSD/IP did not have access. LVN 2 stated C&S result was important to know whether the bacteria were resistant or susceptible to the antibiotic ordered. During an interview on 5/22/26 at 9:50 a.m. with the MDSC, MDSC stated she also shares the IP position, but the DSD/IP was responsible with the antibiotic surveillance log. The MDSC stated C&S result was important, we have to make sure correct antibiotic was ordered. The MDSC stated the C&S result was important to make sure the prescribed antibiotic was appropriate for the type of bacteria causing the infection. The MDSC stated infection will re-occur if bacteria were resistant to the prescribed antibiotic. The MDSC stated all licensed nurses have access to all lab results, if not available they can always call to follow-up to ensure resident was prescribed the appropriate antibiotic. During an interview on 5/22/26 at 11:15 a.m. with the Director of Nursing (DON), the DON stated the DSD/IP was responsible in ensuring the antibiotic surveillance log was accurate and complete to ensure the antibiotic ordered was appropriate to treat the bacteria causing infection. The DON stated the DSD/IP should have made sure she followed up with the C&S results to ensure appropriate antibiotic was ordered and update the primary doctor. The DON stated infections could re-occur if bacteria were resistant to the prescribed antibiotic. The DON stated she was not made aware the DSD/IP did not have access to the lab results. During an interview on 5/22/26 at 11:45 a.m. with the Assistant Administrator (AA), the AA stated he had been in the position for two years and waiting to take his test to be a licensed administrator. The AA stated his expectation was for all staff to have access to all resources they need to do their job. The AA stated, Staff have to let me or the administrator know if they have any concerns or if they need access in order for me to help them find an answer. During a review of the facility's policy and procedure (P&P) titled, Antibiotic (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Stewardship Program, dated 2025, the P&P indicated, .Infection Preventionist-utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic uses starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms . Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to: a. Action plans and/or work plans . b. Assessment forms. c. Antibiotic use protocols/algorithms. d. Data collection forms for antibiotic use, process, and outcome measures . During a review of facility document titled, Infection Preventionist, Job Description, dated 2023, the document indicated, .Develop and implements an ongoing infection prevention and control program to prevent, recognize, and control onset and spread of infections in order to provide a safe, sanitary, comfortable environment . Oversees the facility's antibiotic stewardship program . Leads the facility's Infection and Prevention Control Committee . Implements an annual infection control risk assessment process . Maintains documentation of infection prevention and control program activities . During a review of the professional reference retrieved from https://www.cdc.gov/antibiotic-use/hcp/core-elements/nursing-homes-antibiotic-stewardship.html titled, The Core Elements of Antibiotic Stewardship for Nursing Homes, dated 9/10/25, the professional reference review from The Centers for Disease Control and Prevention (CDC) stated, .standardize the practices which should be applied during the care of any resident suspected of an infection or started on an antibiotic.perform reviews on resident medical records for new antibiotic starts to determine whether the clinical assessment, prescription documentation and antibiotic selection were in accordance with facility antibiotic use policies and practices. When conducted over time, monitoring process measures can assess whether antibiotic prescribing policies are being followed by staff and clinicians.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain an environment free of accident hazards when: 1. Oxygen safety precautions were not implemented for one of thirty two residents (Resident 36) when oxygen equipment was present in Resident 36's room and oxygen-in-use signage was not posted outside the room.This failure had the potential to expose the residents, staff, visitors and emergency responders to accident hazards, including fire or injury, due to unrecognized oxygen use and exposure to ignition sources. 2. One of seven slings (specialized fabric support used with a patient lift to safely transfer individuals with limited mobility between beds, wheelchairs, and commodes) were found with frayed edges and torn corners in the clean linen closet ready for use. This failure had the potential to cause fall and injury when used on residents requiring the use of mechanical lift for transfers. Findings: 1. During a review of Resident 36's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 36 was admitted to the facility on [DATE] with a diagnosis which included pneumonia (a lung infection that made it harder to breath because the lungs could fill with fluid or pus [a thick liquid made of germs, dead cells and the body's infection-fighting cells]) and chronic respiratory failure with hypoxia (a long term condition where the lungs did not work well enough to get enough oxygen into the body, causing hypoxia [low oxygen levels in the body]). During a review of Resident 36's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 36's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 11 indicated Resident 36 was moderately cognitively impaired. During an observation on 5/19/26 at 9:27 a.m., Resident 36 was observed in her room watching television. Resident 36's bed was in the lowest position. An oxygen concentrator was observed on the floor next to the resident's bed; however, the resident was not observed wearing oxygen at the time of observation. Resident 36 declined to participate in an interview. During an interview on 5/20/26 at 3:17 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated it was important to have an oxygen-in use sign posted to alert staff, visitors, and others that oxygen was in use in the area. LVN 1 stated the sign served as a hazard warning to prevent flammable items or ignition sources from being brought into the area. LVN 1 stated if a resident was receiving oxygen, a sign should be posted on the door. LVN 1 stated the risk to the resident was that someone could enter the area, create a spark and ignite the oxygen. During an interview on 5/21/26 at 12:10 p.m. with the Infection Preventionist (IP), the IP stated there should have been an oxygen-in-use sign posted to the residents' door. The IP stated it was important to notify staff, visitors and others that oxygen was in use so appropriate caution could be taken. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of Resident 36's Order Summary Report (OSR), dated 5/22/26, the OSR indicated Resident 36 had an order for nasal cannula oxygen therapy since 5/18/26. During an interview on 5/22/26 at 12:00 p.m. with the Director of Nursing (DON), the DON stated her expectation was that when a resident was receiving oxygen therapy, the resident's room would have necessary oxygen equipment available, including an oxygen concentrator, storage bag, cannula, and an oxygen-in-use sign posted on the door. The DON stated it was staff's responsibility to place the oxygen-in-use signage outside the resident's room. The DON stated the purpose of the sign was to alert staff, visitors, and emergency responders that oxygen was in use, as oxygen presented a fire hazard due to its highly flammable nature. The DON stated it was important for others to be aware of which rooms had oxygen in use in the event of a fire or exposure to an open flame. The DON stated the risk to the resident was potential fire or injury if ignition sources were brought into the area. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2026 the P&P indicated, oxygen warning signs must be placed on the door of the resident's room where oxygen is in use. 2. During a concurrent observation and interview on 5/21/26 at 9:11 a.m. with Laundry Aide (LA) in the laundry area, LA stated she worked full time in the facility and had been working in the laundry department for three years. LA stated she washed the sling in the washer and dried it in the dryer. The LA stated once the slings are dry she bring them in the clean linen closet ready to be used. In the clean linen closet, one sling was found with frayed edges and torn corners. The LA stated she did not inspect the slings when she placed them in the closet ready for use. The LA stated the sling was not safe for use, the torn corners and frayed edges could get bigger and residents could fall. During an interview on 5/21/26 at 8:29 a.m. with Certified Nurse Assistant (CNA) 3, CNA 3 stated she gets a sling from the clean linen closet when using a mechanical lift to transfer residents. CNA 3 stated slings with frayed edges and torn corners should be taken out of the linen closet and not made available to use. CNA 3 stated the torn corners and frayed edges could get bigger and residents could fall during transfer which could result to injury. During an interview on 5/21/26 at 8:35 a.m. with CNA 5, CNA 5 stated slings are stored in the clean linen closet and ready for use. CNA 5 stated it was important to inspect slings prior to use making sure they were safe to be use. CNA 5 stated slings with a torn corner and frayed edges when used could get bigger causing resident to fall and result in injury. During an interview on 5/21/26 at 3:19 p.m. with Environmental Director (ED), the ED stated he had only been in his position for three months. The ED stated slings after washing are air dried and not placed in the dryer. The ED stated placing the sling in the dryer could cause the sling to shrink and destroy the fabric materials. The ED stated laundry department was responsible for checking slings for any signs of wear and tear before placing them in the clean linen closet available for use. The ED stated slings with frayed edges and torn corners should have been pulled out of circulation because it was not safe to use. During an interview on 5/21/26 at 3:36 p.m. with Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated staff had to make sure the appropriate sling size are used on residents. The DSD/IP stated her expectation was for staff to inspect slings for any signs of wear and tear prior to use to prevent accidents and falls. The DSD/IP stated slings placed in the linen closet meant they were available for use. The DSD/IP stated the laundry department was responsible (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in inspecting slings prior to placing them in the clean linen closet. During an interview on 5/22/26 at 11:05 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the laundry department to inspect all the slings for any signs of wear and tear and get rid of slings if found with frayed edges and torn corners. The DON stated nursing staff should be inspecting slings prior to use and making sure sling are safe to use. The DON stated sling with signs of wear and tear like frayed edges and torn corners are not safe for use, resident could fall and sustain injury. During a review of facility's policy and procedure (P&P) titled, Safe Resident Handling/Transfers, dated 2025, the P&P indicated, . The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly . The facility will ensure there are appropriate amounts of varying sizes of slings to accommodate residents . Slings will be laundered according to manufacturer's instructions and any damaged, broken or unsafe slings will be removed from service and replaced . During a review of facility's P&P titled, Fall Prevention Program, dated 2025, the P&P indicated, . Upon admission, the nurse will complete a fall risk assessment . to determine the resident's level of fall risk. The nurse will indicate on the Evaluation the resident's fall risk and initiate interventions .Implement universal interventions that decrease the risk of resident falling, including, but not limited to: . Wheelchairs and assistive devices are in good repair .

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post actual direct care staffing hours worked for public review for 30 of 30 residents in the facility, as required, by posting projected DHPPD (Direct Hours Per Patient Day) staffing information instead of actual hours worked for the prior day. This failure had the potential to prevent residents' family members and visitors from having accurate information regarding the actual nursing staffing levels providing care in the facility. During an observation on 5/19/26 at 9:34 a.m. the facilities publicly posted staffing document titled Rolling Hills Care Center Tuesday, May 19th, 2026 was reviewed. The posting reflected a projected census of 30, projected staff hours of 127 and projected Nurse Hours Per Patient Day (NHPPD) of 4.23. Staff were listed by shift (AM, PM and NOC [night shift]) with estimated hours and assigned staff names for licensed nursing and direct care staff. The document identified the staffing information as projected/estimated staffing hours and did not reflect the actual hours worked for the prior day. During a concurrent interview and review of the facility's Rolling Hills Care Center Tuesday, May 19th, 2026 sheet dated 5/19/26 and Appendix PP tag F732, dated 2/3/23, on 5/21/26 at 11:44 a.m. with the Infection Preventionist (IP), the IP stated staffing needs were determined based on the facility census and did not include bed hold residents. The IP stated the facility aimed to maintain Certified Nursing Assistant (CNA) hours at 2.5 or greater and nursing hours at 3.5 or greater. The IP stated she completed the staffing posting each morning, and the hours posted were projected staffing hours. The IP stated the document was prepared each morning and updated as needed, such as when a new admission occurred. The IP stated if no changes occurred, the posting remained in place until a new document was created the following day. The IP stated there was no designated area on the current posting form to reflect the actual hours worked. The IP stated she had used a form at a previous facility that reflected actual hours worked, but this practice was not utilized at the current facility. The IP stated accurate staffing information was important so residents' families and visitors could see that services were being provided appropriately. The IP stated the facility maintained documentation of the actual staffing hours worked; however, the actual staffing hours were maintained internally and were not posted daily for residents, visitors and the public to review. During the interview, Appendix PP, Tag F732, indicating the requirement to post the actual hours worked, was reviewed with the IP. The IP verbalized understanding of the regulation. During a concurrent interview and review of Appendix PP tag F732, dated 2/3/23, on 5/22/26 at 11:47 p.m. with the Director of Nurses (DON), the DON stated the facility posted expected/projected staffing hours rather than the actual hours worked. The DON stated if the facility had a total of 10 CNA's scheduled, the posted staffing reflected the predicted hours those staff were expected to cover. The DON stated the projected staffing hours were intended to meet or exceed the facilities DHPPD. The DON stated it was her expectation that projected/expected hours be included on the publicly posted staffing sheet. The DON stated it was important for residents, visitors and families to have accurate staffing information so they could determine whether sufficient staff were available to meet resident care needs. The DON stated the facility maintained a sperate staffing document where actual hours worked were tallied; however, this information was not publicly visible. During the interview, Appendix PP, Tag F732, requiring the posting of the actual hours worked, was reviewed with the DON, the DON verbalized understanding that the public staffing posting was required to reflect the actual hours worked rather than projected staffing hours. During a review of facilities policy and procedure (P&P) titled, Nurse Staffing Posting Information, dated 2025, the P&P indicated, The Nurse Staffing Sheet will be posted on a daily basis and will contain the following information: d. the total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: i. Registered Nurses, ii. Licensed Practical Nurses/Licensed Vocational nurses iii. Certified Nurse Aids.3. The information posted will be: b. in a prominent place readily accessible to residents, staff and visitors.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interview and review of facility documents, the facility failed to ensure menus were followed for the lunch meal on 5/19/26 when the facility served: 1) A #12 scoop (1/3 cup) of cauliflower instead of #8 (1/2 cup) of peas for five residents (Residents 4, 26, 35, 37 and 20);2) One resident on a soft and bite sized diet (Resident 25) received 1/3 cup instead of 1/2 cup of cauliflower; and3) Four residents on a renal diet (Resident 35, 37, 20 and 28) 1/2 cup instead of 1/3 cup of oven browned potatoes. This failure has the potential to result in residents not meeting the micronutrients (referred to as vitamins and minerals, are vital to healthy development, growth, disease prevention, and well-being) in the physician prescribed therapeutic diets which could compromise nutritional and medical status.During an observation of the lunch meal service, in the dining room, on 5/19/26 at 11:43 a.m., there were pans of the following in the steam table (a commercial food service kitchen appliance to keep food warm, it is equipped with wells that hold heated water or steam) pork chops with sauteed onions, oven browned potatoes with a #8 scoop, green peas with a #8 scoop and steamed cauliflower with a #12 scoop. 1. During a review of the lunch menu for 5/19/26, it indicated for the regular and puree diet the following: smothered pork chop, three ounces and #8 scoop, respectively; #8 scoop for oven browned potatoes and # 8 scoop for seasoned green peas. For the liberalized renal diet it indicated a smothered pork chop, three ounces, #12 scoop oven browned potatoes, and #8 scoop seasoned green peas. During an observation of the lunch meal service, in the dining room, on 5/19/26 starting at 11:43 a.m., [NAME] 1 gave Food Service Worker 1 (FSW 1) six bowls of puree food items to put on Resident 26 and 4's meal trays. Surveyor asked FSW 2 to open the covered bowls. Puree cauliflower, potatoes and pork were in the bowls. (Cross Reference F804 and F805). During a review of Resident 26's meal ticket showed a consistent carbohydrate (CCHO- a diet designed to stabilize blood sugar levels by eating the exact same amount of carbohydrates at every meal) puree diet. The bowls of puree cauliflower, potatoes, and pork were placed on the lunch meal tray. During a review of Resident 4's meal ticket showed a puree diet with mildly thick liquids (flow like a thick cream soup or runny honey, recommended for people with swallowing difficulties). The bowls of puree cauliflower, potatoes, and pork were placed on the lunch meal tray. During the lunch meal observation in the dining room on 5/19/26, starting at 11:43 a.m., [NAME] 1 was scooping and serving cauliflower, pork and potatoes for Residents 35, 27, and 20. During a concurrent observation and review of Resident 35, 37 and 20's meal tickets indicated a liberalized renal diet. 2. During the lunch meal observation in the dining room on 5/19/26, starting at 11:43 a.m., [NAME] 1 was scooping and served #12 scoop of cauliflower to Resident 25's plate on the lunch tray. A concurrent review of Resident 25's meal ticket indicated a , no added salt, soft and bite sized diet. During a review of the lunch menu for 5/19/26 indicated for a soft and bite sized diet there were to get #8 scoop of bite sized smothered pork chop with puree gravy, #8 scoop oven browned potatoes, #8 bite sized soft chef's vegetable of choice. 3. During a review of the lunch menu for 5/19/26, it indicated for the liberalized renal diet a smothered pork chop, three ounces, #12 scoop oven browned potatoes, and #8 scoop seasoned green peas. During the lunch meal observation in the dining room on 5/19/26, starting at 11:43 a.m., [NAME] 1 was scooping and served #8 scoop of oven browned potatoes for Residents 35, 37, 20 and 28 and placed them on the plates and trays in the meal cart. During a concurrent observation and review of Resident 35, 37 and 20's meal tickets indicated a liberalized renal diet. Resident 35, 37 and 20 received #8 scoop of oven browned potatoes, #12 scoop of cauliflower, and a pork chop. During a review of Resident 28's meal ticket showed a liberalized renal, large portion diet and disliked vegetables. Resident 28's received a hamburger and #8 scoop of potatoes. During an interview once lunch meal service was completed with [NAME] 1 on 5/19/26 at 12:05 p.m., [NAME] 1 confirmed she used #12 scoop for cauliflower and #8 scoop for oven brown potatoes. During a concurrent review of the lunch menu with [NAME] 1, [NAME] 1 confirmed that the (continued on next page)

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Rolling Hills Care Center	2108 Stillman Selma, CA 93662

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	renal diet should have gotten #12 scoop of potatoes and that she put in the incorrect scoop in the cauliflower and potatoes. During an interview with the Registered Dietitian (RD) on 5/20/26 at 2:04 p.m., RD stated her expectation is for staff to follow menus and portion sizes. RD acknowledged that the menus need to be near the lunch meal service for them to reference during meal service. During a review of the facility policy and procedure titled Food Preparation Guidelines dated 2026, indicated the cook shall prepare menu items following the facility's written menus.

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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 and record review, the facility failed to ensure one of seven sampled residents (Resident 15) was informed in advance, by the physician of the risks and benefits of proposed treatment when Resident 15 did not have a signed physician informed consent (a process in which a healthcare professional educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) prior to the administration of venlafaxine HCL (an antidepressant prescription medication used to relieve symptoms of depression such as feelings of sadness or loss of interest in activities). This failure resulted in Resident 15 receiving medication without being informed of the risks, benefits, or alternatives, limiting the resident's ability to make informed decisions about their care.During a concurrent interview and record review on 5/21/26 at 4:11 p.m. with the Director of Nursing (DON), Resident 15's Psychotherapeutic Drug Informed Consent Form (PDIC) for venlafaxine HCL dated 5/5/26, was reviewed. The PDIC was missing the physician's signature in the prescriber signature section and was instead electronically signed by Licensed Vocational Nurse (LVN) 3. The DON stated PDIC's are signed by the resident or responsible party and the prescribing physician after the resident is informed of the risks, benefits and alternatives. The DON stated the PDIC for venlafaxine HCL was signed by LVN 3 and Resident 15. The DON stated there was not a physician's signature on the PDIC. The DON stated the expectation was the PDIC should be signed by the physician. The DON stated it was important to have a completed PDIC because it showed that the resident was properly informed of the risks, benefits and alternatives. The DON stated it was the doctor's responsibility to inform residents of medication risks, benefits and alternatives. The DON stated without a signature on the Resident 15's PDIC there was no documentation the resident was informed of the side effects.During a review of Resident 15's admission Record (AR), dated 5/21/26, the AR indicated, Resident 15 was admitted to the facility on [DATE] with the diagnosis of .major depressive disorder, recurrent.During a review of Resident 15's Order Summary Report (OSR), dated 5/21/26, the OSR indicated, Resident 15 had a physician's order for . Venlafaxine HCL oral tablet 50 [milligram -unit of measurement] . Give 1 tablet by mouth one time a day related to Major Depressive Disorder .During a review of the facility's policy and procedure (P&P) titled Use of Psychotropic Medications, dated 2026, the P&P indicated, . Prior to initiating . a psychotropic medication, the resident . must be informed of the benefits, risks, alternatives . in advance of such initiation . The facility will document that the resident . was informed in advance of the risks and benefits . in a format the facility deems to use (e.g. written consent form.) .

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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 ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for three of five sampled residents (Residents' 20, 21, and 35) when: 1. Resident 20 and 35 did not have a care plan for Enhanced Barrier Precaution (EBP-refer to an infection control intervention designed to reduce transmission of multi-resistant drug organisms that employ targeted gown and gloves use during high contact resident care activities) secondary to having dialysis access port. This failure placed Resident 20 and Resident 35 at risk of cross-contamination (unintentional transfer of harmful bacteria, virus, or allergens from one surface, object, or food to another) and not meeting their needs and care. 2. Resident 21's duloxetine (medication used to treat depression) medication was ordered on 3/10/26, care plan was not initiated until 4/29/26. This failure placed Residents 20, 21 and 35 at risk for harm by not identifying and monitoring side effects of duloxetine. 1. During a concurrent observation and interview on 5/20/26 at 11:10 a.m. in Resident 20's room, Resident 20 was observed sitting at the edge of his bed, appropriately dressed and well groomed. Resident 20 stated he goes to dialysis three days a week every Tuesday, Thursday and Saturday. Resident 20's dialysis port on his right chest with gauze (thin, translucent fabric with loose, open weave, most commonly made of cotton) and medipore tape (hypoallergenic, soft cloth surgical tape). During a review of Resident 20's admission Record [AR-a document containing resident profile information], dated 5/22/26, the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses which included dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), shortness of breath and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a concurrent observation and interview on 5/19/26 at 9: 36 a.m. in Resident 35's room, Resident 35 stated he goes to dialysis every Tuesday, Thursday and Saturday. Resident 35's fistula (an abnormal tunnel or connection between two organs, vessels, or tubes) was on his left upper arm. Resident 35 stated only dialysis staff checked the site. During a review of Resident 35's AR dated 5/22/26, the AR indicated Resident 35 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD- irreversible kidney failure), chronic obstructive pulmonary disease (COPD-chronic lung disease causing difficulty in breathing) and hyperkalemia (too much potassium in the blood). During a concurrent interview and record review on 5/21/26 at 9:16 a.m. with Minimum Data Set Coordinator (MDSC), the MDSC reviewed Resident 20's clinical record and stated Resident 20 was admitted to the facility on [DATE]. The MDSC stated Resident 20 was a dialysis resident and was an EBP. The MDSC stated she did not find a care plan for EBP and there should have been. The MDSC reviewed Resident 35's clinical record and stated Resident 35 was admitted to the facility on [DATE] and the EBP care plan was initiated 5/20/26. The MDSC stated it was the responsibility of the Director of Staff Development/Infection Preventionist (DSD/IP) to ensure there was a care plan in place. The MDSC stated a care plan was important in order for nursing staff to care for residents and monitor their conditions. 2. During concurrent observation and interview on 5/19/26 at 9:07 a.m. during the initial tour in Resident 21's room, Resident 21 was lying in bed watching TV. Resident 21 stated he had been in the facility for two months and was working with therapy for a broken left hand/arm sustained from a fall at home. Resident 21 stated he gets out of bed everyday to work with therapy and sometimes eats in the dining room but preferred eating in his room. During a review of Resident 21's AR dated 5/21/26, the AR indicated Resident 21 was admitted to the facility on [DATE] with diagnoses which included depression (persistent sadness, loss of interest in activities, and an inability to experience joy), fracture of shaft of left ulna (broken forearm) and muscle (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness. During a review of Resident 21's clinical record titled, Order Details, dated 5/22/26, the Order Details indicated, Duloxetine HCl [hydrochloride] Oral capsule Delayed Release Particles 60 MG [milligram-unit of measurement] Give 60mg by mouth at bedtime for m/b [manifested by] Self Isolation related to Depression, Unspecified . During a review of Resident 21's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 21's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognitive status) 0-15 scale (0-6- severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 14 out of 15 which indicated Resident 21 had no cognitive deficit. During a concurrent interview and record review on 5/21/26 at 2:09 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 reviewed Resident 21's clinical record. LVN 1 stated Resident 21 was admitted to the facility on [DATE] with the duloxetine medication. LVN 1 stated Resident 21's duloxetine care plan was initiated on 4/29/26, LVN 1 stated care plan should have been initiated within 24 hours of admission. LVN 1 stated care plan was every licensed nurses responsibility and it provide nursing staff guidance on how to care for residents. During an interview on 5/22/26 at 9:03 a.m. with LVN 2, LVN 2 stated care plans are the responsibilities of all licensed nurses. LVN 2 stated care plans directs nursing staff on how to take care of residents and to monitor for any side effects of medications and complications. LVN 2 stated care plans should be initiated as soon as a medication order was received. During an interview on 5/21/26 at 3:45 p.m. with Director of Staff Development/Infection Preventionist (DSD/IP), the DSD/IP stated all residents with medical device such as catheter, dialysis port, tube feeding and residents with wounds are automatically placed on EBP. The DSD/IP stated residents on EBP should be care planned right away on admission and followed up by IP. During an interview on 5/22/26 at 10:52 a.m. with the Director of Nursing (DON), the DON stated her expectation was to ensure a care plan was initiated as soon as an issue occurred or identified. The DON stated care plans should be initiated immediately for any new medications received. The DON stated for new admissions in the facility and infection control issues are identified, the admitting nurse should initiate a care plan immediately within 24 hours then the Infection Preventionist will follow-up. During a review of facility policy and procedure (P&P) titled, Comprehensive Care Plans, dated 2025, the P&P indicated, It is the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes . The comprehensive care plan will describe . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. Any services that would otherwise be furnished . The resident's goals for admission, desired outcomes, and preferences . Resident specific interventions that reflect the resident's needs and preferences . During a review of facility policy and procedure (P&P) titled, Hemodialysis, dated 2025, the P&P indicated, . The staff will ensure that appropriate Personal Protective Equipment [PPE] id worn and follow current infection control practices when assessing dialysis access sites .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet professional standards of practice for two of five sampled residents (Resident 20 and Resident 35) when Resident 20 and Resident 35 did not have an order for Enhance Barrier Precautions (EBP-refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities) upon admission to the facility due to presence of hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) catheters. This deficient practice placed Resident 20 and resident 35 at risk of cross contamination which could lead to more serious health conditions. During a concurrent observation and interview on 5/20/26 at 11:10 a.m. in Resident 20's room, Resident 20 was observed sitting at the edge of his bed, appropriately dressed and well groomed. Resident 20 stated he goes to dialysis three days a week every Tuesday, Thursday and Saturday. Resident 20's dialysis port on his right chest with gauze (thin, translucent fabric with loose, open weave, most commonly made of cotton) and medipore tape (hypoallergenic, soft cloth surgical tape). During a review of Resident 20's admission Record [AR-a document containing resident profile information], dated 5/22/26, the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses which included dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), shortness of breath and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing. During a concurrent observation and interview on 5/19/26 at 9: 36 a.m. in Resident 35's room, Resident 35 stated he goes to dialysis every Tuesday, Thursday and Saturday. Resident 35's fistula (an abnormal tunnel or connection between two organs, vessels, or tubes) on his left upper arm. Resident 35 stated only dialysis staff checked the site. No EBP precautions observed on the door. During a review of Resident 35's AR dated 5/22/26, the AR indicated Resident 35 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD- irreversible kidney failure), chronic obstructive pulmonary disease (COPD-chronic lung disease causing difficulty in breathing) and hyperkalemia (too much potassium in the blood). During a concurrent interview and record review on 5/21/26 at 9:20 a.m. with Minimum Data Set Coordinator (MDSC), the MDSC reviewed Resident 20 and Resident 35's clinical records. The MDSC stated Resident 20 was admitted to the facility on [DATE] and goes to dialysis. The MDSC stated she did not find Resident 20's order for EBP and there should be. The MDSC stated Resident 35 was admitted to the facility on [DATE] and goes to dialysis. The MDSC stated Resident 35's EBP order was dated 5/20/26, the MDSC stated, the order should have been placed on admission. The MDSC stated the DSD/IP was in charge of making sure there was an order for EBP in place. During a concurrent interview and record review on 5/21/26 at 3:45 p.m. with the Director of Staff Development/Infection Preventionist (DSD/IP), Resident 20 and Resident 35's clinical records were reviewed. The DSD/IP stated Resident 20 and Resident 35 goes to dialysis three days a week. The DSD/IP stated Resident 20 and Resident 35 should have been an order for EBP on admission and placed on EBP immediately to ensure safety and prevent cross contamination (unintentional transfer of harmful bacteria, virus, or allergens from one surface, object, or food to another). The DSD/IP stated the admission nurse should have made sure to include an order for EBP when Resident 20 and Resident 35 were admitted to the facility then the IP will review and follow-up. The DSD/IP stated any residents with medical devices like dialysis port, catheter and wounds are automatically placed on EBP. During an interview on 5/22/26 at 9:10 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated any residents with wounds, dialysis port and catheters should be placed on EBP. LVN 2 stated admission nurse are responsible in ensuring order for EBP was in placed on admission. LVN 2 stated the DSD/IP was responsible in reviewing new admissions and EBP orders was in-placed for residents meeting criteria. During an interview on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/22/26 at 11:05 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the admission nurse to ensure EBP order was in placed for any residents with medical devices or lines like dialysis ports and wounds and not wait for the IP. The DON stated the night nurse then followed up with the admission. The DON stated the IP follow-up and ensured there was an order in placed. The DON stated new admissions are reviewed in the morning meetings to ensure resident records are accurate and complete. The DON stated it was important to ensure an order was in placed to prevent cross contamination which could lead to more serious health conditions. During a review of facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution, dated 2025, the P&P indicated, .An order for enhanced barrier precautions will be obtained for residents with any of the following .indwelling medical devices [.hemodialysis catheters] even if the resident is not known to be infected . The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education . Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk .

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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 and record review, the facility failed to act upon a Medication Regimen Review (MMR) irregularity for one of seven sampled residents (Resident 24) when the facility's Consultant Pharmacist recommended Resident 24's calcium (a mineral needed for bones, teeth, muscles, and nerves) administration time be changed to 10:00 a.m. or later due to medication interaction with levothyroxine (medication that replaces the natural thyroid hormone the body is missing and must be taken on an empty stomach), scheduled for 6:00 a.m. Resident 24's calcium administration time was instead changed to 8:00 a.m. without obtaining the required physician documentation.These failures resulted in the Consultant Pharmacists recommendations not being reviewed by the doctor and the potential to reduce the effectiveness of levothyroxine, placing Resident 24 at risk for the return of hypothyroid (a condition where the thyroid gland does not produce enough thyroid hormones) symptoms including weight gain, fatigue or cold intolerance.During a concurrent interview and record review on 5/21/26 at 4:23 p.m. with the Director of Nursing (DON), Resident 24's Consultant Pharmacist Medication Regimen Review (CPMRR), dated 12/23/25, was reviewed. The CPMRR indicated, the Consultant Pharmacist recommended changing the administration time of Resident 24's calcium to 10:00 a.m. or later due to interactions with her levothyroxine medication. The DON stated when a recommendation is received from the Consultant Pharmacist during a medication regimen review, she reviews the nursing aspect of the recommendation and then faxes the CPMRR to the physician. The DON stated the physician will write on the CPMRR if he agrees with the recommendation (a new order is written for the resident) or disagrees with the recommendation then send it back to the facility. The DON stated when she received a new order she adds the new order into the resident's electronic health record (EHR). The DON stated she was responsible for following up on all recommendations.During a concurrent interview and record review on 5/22/26 at 8:45 a.m. with the DON, Resident 24's Medication Administration Record (MAR), dated 01/2026 was reviewed. The MAR indicated, Resident 24's calcium administration time was changed on 1/4/26 from 10:00 a.m. to 8:00 a.m. The DON stated she was unable to locate documentation that the Physician was aware of the Consultant Pharmacist recommended Resident 24's calcium administration time change to 10:00 a.m. or later. The DON stated the MAR reflected a change in administration time from 10:00 a.m. to 8:00 a.m. which was two hours earlier than recommended. The DON stated that taking levothyroxine and calcium to close together may decrease Resident 24's absorption of the thyroid medication and it could be ineffective. During a review of Resident 24's admission Record (AR), dated 5/27/26 the AR indicated, Resident 24 was admitted to the facility on [DATE] with diagnosis including .Hypothyroidism, unspecified. during her stay.During a review of Resident 24's Order Summary Report (OSR), dated 5/21/26, the OSR indicated, Resident 24 had an active order for .Calcium/D3 [vitamin D3] oral tablet 500-5 mg [milligram - unit of measurement -mcg [microgram - unit of measurement] .Give 1 tablet by mouth one time a day for supplement. and .[levothyroxine] oral tablet.Give 100mcg by mouth in the morning for Hypothyroid.During a review of the facility's policy and procedure (P&P) titled Medication Regimen Review (MRR), dated 2026, the P&P indicated, .Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.During a review of the facility's P&P titled Addressing Medication Regimen Review Irregularities (AMRRI), dated 2026, the P&P indicated, .It is the policy of this facility to provide Medication Regimen Review (MRR) for each resident in order to identify irregularities and respond to those irregularities in a timely manner.the reports must be acted upon.The attending physician must document in the resident's medical record that the identified irregularity has been reviewed.During a professional reference review retrieved from National Library of Medicine/National Center for Biotechnology Information found at https://pmc.ncbi.nlm.nih.gov/articles/PMC3092723/, (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Absorption of Levothyroxine When Coadministered with Various Calcium Formulation, dated 05/11, the professional reference review indicated .Coadministration of each of the three calcium preparations significantly reduced levothyroxine absorption by about 20%-25% compared with levothyroxine given alone.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 37) was free from unnecessary drugs when Resident 37's use of anticoagulant medication (refers to class of medication that are used to prevent clot extension and formation) had no monitoring for side effects. This failure resulted in Resident 37 receiving medication and had the potential to experienced side effects of medication without proper monitoring. During a concurrent observation and interview on 5/19/26 at 9:05 a.m. with Resident 37 in the hallway outside of room [ROOM NUMBER]. Resident 37 was observed sitting up in his wheelchair and was assisted by staff, left foot wrapped with gauze dressing (medical cloth patch or gauze made of loosely woven cotton), Resident 37 stated his left small toe was surgically amputated. During a review of Resident 37's admission Record, (AR-a document containing resident profile information), dated 5/21/26, the AR indicated Resident 37 was admitted to the facility on [DATE] with diagnoses which included absence of other left toe(s), chronic (long lasting) embolism (blockage of a blood vessel) and thrombosis (formation of a blood clot inside a blood vessel or the heart, which restricts or blocks the normal flow of blood) of other specified veins. During a review of Resident 37's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 37's Brief Interview for Mental Status (BIMS-screening tool sed to assess resident cognitive status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit)assessment score was 15 out of 15 which indicated Resident 37 had no cognitive deficit. During a review of Resident 37's clinical document titled, Order Summary Report, dated 5/22/26, the Order Summary Report indicated, . [brand name] Oral Tablet 20 MG (milligram- unit of measurement) . related to CHRONIC EMBOLISM AND THROMBOSIS OF OTHER SPECIFIED VEINS . Order Date: 5/14/26, Start Date: 5/15/26 . During a concurrent interview and record review on 5/22/26 at 9:03 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 reviewed Resident 37's clinical record and stated she was familiar with Resident 37's care. LVN 2 stated Resident 37 was admitted to the facility on [DATE] and was admitted with the anticoagulant medication. LVN 2 stated she did not find an order for monitoring for the side effects of the anticoagulant medication. LVN 2 stated there should have been monitoring order in place but there was none. LVN 2 stated monitoring was important to monitor for presence of bleeding and any side effects like presence of blood in the stools and urine. During a concurrent interview and record review on 5/22/26 at 9:45 a.m. with Minimum Data Set Coordinator (MDSC), Resident 37's clinical record was reviewed. The MDSC stated she did not find monitoring order for Resident 37's anticoagulant order. The MDSC stated it was important to monitor use of anticoagulant to monitor any signs of bleeding which could lead to serious health problems. During an interview on 5/22/26 at 11:05 a.m. with the Director of Nursing (DON), the DON stated her expectation was for licensed nurses to ensure monitoring of anticoagulant use was in placed as soon as medication order was received. The DON stated, Resident 37 could have bleeding issues staff are not aware of which could lead to more serious health issues. The DON stated it was important to monitor anticoagulant use to monitor any signs and symptoms of bleeding to prevent complications. During a review of facility policy and procedure (P&P) titled High Risk Medications- Anticoagulant, dated 2026, the P&P indicated . Anticoagulants shall be prescribed by a physician or other authorized practitioner with clear indications for use . Routine labs, including baseline and subsequent labs shall be ordered for each resident requiring anticoagulant medication . The resident's plan of care shall alert staff to monitor adverse consequences .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and review of facility documents, the facility failed to ensure there was a full time qualified Dietary Manager (DM) met state requirements, California Health and Safety Code (CA HSC) 1265.4(b) when the Registered Dietitian (RD) was not employed full-time. This failure resulted in puree food not in the proper form, puree foods not being prepared by methods that conserve nutritive value and flavor, menus not being followed and food stored not being monitored for cool down procedures for the 31 residents admitted to the facility. (Cross Reference F803, 804, 805, 812). During a review of the California Health and Safety Code (CA HSC) 1265.4 (a), If the facility employs a RD less than full-time, they shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations. 1265.4 (b) stated, the dietetic services supervisor shall have completed one of seven recognized pathways, two of which include the completion of an education program approved by the Dietary Managers Association and successful completion of a certifying exam. In addition to the successful completion of a certifying exam the qualified manager must have received at least six hours of in-service training on the specific California dietary service requirements contained in Title 22 of the California Code of Regulations prior to assuming full-time duties as a dietetic services supervisor at the health facility. During an interview on 5/19/26 at 8:42 a.m with the DM and the Certified Dietary Manager (CDM), the CDM stated she is the CDM but only works at the facility part time or as needed but helps with the clinical only. The DM stated she is currently enrolled in a program, is about halfway complete and under supervision of the RD. DM stated the RD is usually at the facility once a week. During a review of DM personnel file on 5/20/26 at 10:11 a.m., the DM job description indicated the required qualifications was a certification as a dietary manager and must also meet State requirements for food service or dietary managers signed and dated on 7/30/25 by DM and administrator signature and dated 7/31/25. During an interview with the RD on 5/20/26 at 2:04 p.m., RD stated that about two weeks ago, this is her only building and the plan is for her to be at the facility at least eight hours a week but it may be more hours per week depending on the needs. During an interview with the Administrator (ADM) on 5/20/26 at 3:19 p.m., ADM stated the RD works in the building about eight hours a week and the CDM got another job so only works as needed. ADM stated the DM is in school and not qualified at this time.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of facility documents, the facility failed to ensure puree foods were prepared by methods that conserve nutritive value and flavor when [NAME] 1 made puree roasted potatoes and cauliflower were prepared with water for two residents (Residents 4 and 26) that were on a physician's prescribed puree diet. This can result in residents receiving improper nutrients from the food which can result in a decrease in meeting the nutrient needs which can further compromise their medical status. During an observation in the kitchen and concurrent interview with [NAME] 1 on 5/19/26 at 10:21 a.m, [NAME] 1 scooped two #8 (1/2 cup) scoop portions into blender then added, #24 scoop (1-1/3 ounces) butter, and five ounces of hot water from hot water dispenser spicket then blended. The measuring cup contained 8 ounces of hot water then after hot water was poured into blender there were three ounces of hot water left. [NAME] 1 used plastic spoon to stir then poured into two bowls. The puree potatoes had flecks of skin present, appeared very thin and watery. [NAME] 1 stated she is looking for creamy texture and only uses plastic spoon to stir food. [NAME] 1 stated after it sits she will determine if any thickener is needed. [NAME] 1 stated there was not a way to determine if food was the proper consistency and was just looking for creamy. During an observation in the kitchen and concurrent interview with [NAME] 1 on 5/19/26 at 10:41 a.m., while preparing the puree cauliflower. [NAME] 1 used two #8 scoops of cooked cauliflower, three ounces of hot water, two pumps of thickener and #24 scoop of butter. Cauliflower appeared to be thin. During a lunch meal observation, in the dining room, on 5/19/26 starting at 11:43 a.m., six bowls of puree food items were on the steam table. A concurrent observation and record review of the lunch meal ticket for Resident 26 and 4 at this time, indicated a consistent carbohydrate (CCHO - a diet designed to stabilize blood sugar levels by eating the exact same amount of carbohydrates at every meal) puree diet with thin liquids and a no added salt, puree diet with mildly thick liquids (flow like a thick cream soup or runny honey, recommended for people with swallowing difficulties) respectively. [NAME] 1 gave three bowls of puree foods to Food Service Worker (FSW 1) to place on the trays for the residents respectively. The puree strawberry crisp was on the trays in the cart. During a review of Resident 4's face sheet (FS), dated 5/20/26, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included dysphagia, unspecified (difficulty swallowing), mild protein-calorie malnutrition (early-stage nutritional deficiency where insufficient intake of calories and protein leads to subtle physical or metabolic changes). During a review of Resident 26's FS, dated 5/20/26, indicated Resident 26 was admitted to the facility on [DATE] with diagnoses that included dysphagia oropharyngeal phase (a medical condition characterized by difficulty initiating a swallow and transferring food or liquid from the mouth into the throat and esophagus), and moderate protein-calorie malnutrition (a nutritional deficit where a person takes in 50% to 75% of their energy needs leading to mild to moderate weight loss and some loss of muscle mass). During a review of the pureed oven browned potatoes recipe, dated 2026, indicated to place the number of servings needed from the regular prepared recipe, and blend in a food processor until smooth. If the consistency needs thinning: gradually add an appropriate hot liquid (i.e. broth, gravy, hot milk, sauce or reserved cooking liquid). During a review of the pureed cauliflower recipe dated 2026, it indicated to place the prepared vegetables and margarine in food processor and blend until smooth. It indicated under note: any liquid specified in the recipe is a suggested amount if needed and some recipe items will require no liquid added to achieve the desired consistency. It indicated if product needs thinning to gradually add an appropriate amount of liquid (NOT WATER). During an interview with the Registered Dietitian (RD) on 5/20/26 at 2:04 p.m., RD stated that water should never be used when preparing puree foods and the staff can use either milk, margarine, broth, gravy or sauce. RD stated using five ounces of water seemed like a lot for just two portions of puree and that would affect the nutritive value of the food. During a review of the facility Diet Manual for Puree diet, dated 2022, indicated to never use water as (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the liquid added to a pureed item. During a review of the facility policy and procedure titled Food Preparation Guidelines dated 2026, indicated the policy of the facility to prepare foods in a manner to preserve or enhance a residents' nutrition and hydration status. It indicated the cook shall prepare menu items following the facility's standardized recipes and food shall be prepared by methods that conserve nutritive value, flavor and appearance.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and review of facility documents, the facility failed to ensure puree food was in the proper form for two sampled residents (Residents 4 and 26) on their lunch meal tray on 5/19/26. This failure has the potential to result in choking (when the airway is obstructed by food, drink, or foreign objects) for Residents 4 and 26 who were on the physician prescribed therapeutic diet. During an observation in the kitchen and concurrent interview with [NAME] 1 on 5/19/26 at 10:21 a.m, [NAME] 1 scooped two #8 (1/2 cup) scoop portions into blender then added, #24 scoop (1-1/3 ounces) butter, and five ounces of hot water from hot water dispenser spicket then blended. The measuring cup contained 8 ounces of hot water then after hot water was poured into blender there were three ounces of hot water left. [NAME] 1 used plastic spoon to stir then poured into two bowls. The puree potatoes had flecks of skin present, appeared very thin and watery. [NAME] 1 stated she is looking for creamy texture and only uses plastic spoon to stir food. [NAME] 1 stated after it sits she will determine if any thickener is needed. [NAME] 1 stated there was not a way to determine if food was the proper consistency and was just looking for creamy. During an observation in the kitchen and concurrent interview with [NAME] 1 on 5/19/26 at 10:41 a.m., while preparing the puree cauliflower. [NAME] 1 used two #8 scoops of cooked cauliflower, three ounces of hot water, two pumps of thickener and #24 scoop of butter. Puree cauliflower appeared a thin consistency. No testing of the puree cauliflower was done by [NAME] 1. During an observation, in the kitchen, on 5/19/2026 at 10:50 a.m., with a concurrent interview with Food Service Worker 2 (FSW 2), FSW 2 stated she is making dessert for two residents on the puree diet. Observed FSW 2 used two little plastic cups previously portioned of strawberry crisp. The cups were not completely filled and crips were put in small food processor with 2% milk not measured and a 1/2 pump food thickener. Then processed. FSW 2 stated she was looking for pudding consistency. FSW 2 confirmed she just looked for the consistency of pudding and she did not test it any way. FSW 2 stated she would just eye the milk to determine how much was needed when preparing the puree strawberry crisp. FSW 2 stated she thought it needed some more thickener and stated she was using another 1/2 pump. Observed FSW 2 then blend more then pour half of the mixture in two swirl cups. The cups were halfway full on the counter. During an observation and concurrent interview on 5/19/26 at 11:01 a.m., the Certified Dietary Manager (CDM) asked FSW 2 if she had measured the puree strawberry crisp. FSW 2 stated she measured the amount that was put in the food processor. Surveyor asked CDM to measure the amount in the swirl cups of puree strawberry crisp. The CDM used a spatula and put into a #8 scoop and it was about one ounce short of filling the scoop. The CDM told FSW 2 to make more strawberry crisp puree. FSW 2 did the same method to prepare more. Once completed she used a #8 scoop to portion both cups with puree strawberry crisp. It was unclear if the puree strawberry crisp was the proper consistency. During a lunch meal observation, in the dining room, on 5/19/26 starting at 11:43 a.m., six bowls of puree food items were on the steam table. A concurrent observation and record review of the lunch meal ticket for Resident 26 and 4 at this time, indicated a consistent carbohydrate (CCHO - a diet designed to stabilize blood sugar levels by eating the exact same amount of carbohydrates at every meal) puree diet with thin liquids and a no added salt, puree diet with mildly thick liquids (flow like a thick cream soup or runny honey, recommended for people with swallowing difficulties) respectively. [NAME] 1 gave three bowls of puree foods to food service worker (FSW 1) to place on the trays for the residents respectively. The puree strawberry crisp was on the trays in the cart. During a review of Resident 4's face sheet (FS), dated 5/20/26, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses that included dysphagia, unspecified (difficulty swallowing). During a review of Resident 26's FS, dated 5/20/26, indicated Resident 26 was admitted to the facility on [DATE] with diagnoses that included dysphagia oropharyngeal phase (a medical (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	condition characterized by difficulty initiating a swallow and transferring food or liquid from the mouth into the throat and esophagus). During a review of the pureed oven browned potatoes recipe, puree cauliflower recipe, and puree strawberry peach crisp recipe, dated 2026, all indicated to perform appropriate International Dysphagia Diet Standardization Initiative (IDDSI) testing to ensure texture standards are met. During an interview with the Registered Dietitian (RD) on 5/20/26 at 2:04 p.m., RD stated that she expects staff to test for consistency as according to IDDSI and to do the spoon test after making the puree foods. RD stated she trained staff twice on the IDDSI diets and testing even showing videos as well as completed one on one training with them. RD stated it is her expectation that staff follow recipes. During a review of the facility in-services dated 3/2/26, indicated the subjects covered were IDDSI framework, what is the fork test, drink and food levels that included puree. It indicated names and signatures of kitchen staff present. FSW 2 was present, however, [NAME] 1 was not. No evaluation of competency was provided by the facility from the in-service. During a review of the facility in-service dated 12/19/25, indicated subjects covered were new recipes and diets, IDDSI. It indicated the summary and conclusion was to learn and understand new diets, textures and recipes. [NAME] 1 and FSW 2 were present. No evaluation of competency of staff was provided by the facility for the in-service. During a review of the IDDSI framework and detailed definitions, dated April 2026, indicated under the Puree Extremely Thick level 4, indicated under description/characteristics that it shows some very slow movement under gravity but cannot be poured, falls off spoon in a single spoonful when tilted and continues to hold its shape on a plate. It indicated to use IDDSI testing methods to decide if the food meets IDDSI level 4. It indicated for a fork drip test that the sample sits in a mound/pile above the fork; a small amount may flow through and form a short tail below the fork tines/prongs but it does not flow or drip continuously through the prongs of a fork. It indicated under the spoon tilt test, that the food is cohesive enough to hold its shape on the spoon and a full spoonful must plop off the spoon if the spoon is titled or turned sideways; a very gentle flick (using only fingers and wrist maybe necessary to dislodge the sample from the spoon, but the same should slide off easily with very little food left on the spoon. It further indicated that a thin film remaining on the spoon is acceptable however you should still be able to see the spoon through the thin film and the sample should not be firm and sticky. During a review of the facility policy and procedure titled Food Preparation Guidelines, dated 2026, indicated food shall be provided in a form (i.e.pureed) that meets each resident's individual needs.

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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. Based on interview and record review, the facility failed to maintain accurate and confidential medical records in accordance with accepted professional standards and practices for one of five sampled residents (Resident 15) when Resident 15's electronic health record (EHR) contained annual History and Physicals (H&P - A comprehensive assessment of a person's medical history), that belonged to five different residents (Residents 6, 17, 24, 40, and 41).These failures resulted in the compromised accuracy of Resident 15's medical records and violated the confidentiality of Protected Health Information (PHI - any health-related information that identifies a specific person) for Residents 6, 17, 24, 40, and 41.Findings: During a concurrent interview and record review on 5/21/26 at 3:44 p.m. with Medical Records/Activities Director (MR/AD), Resident 15's EHR document titled Annual H&P Examination, dated 12/28/2025, was reviewed. Resident 15's Annual H&P Examination included H&P's that belonged to Residents 6, 17, 24, 40 and 41. MR/AD stated the records for Residents 6,17, 24, 40 and 41 were uploaded into the wrong resident's chart. MR/AD stated the H&P records for Residents 6, 17, 24, 40 and 41 should not have been in Resident 15's EHR. MR/AD stated the expectation at the facility was that each resident documents uploaded into the EHR should be verified through the review of the resident's name and date of birth (DOB) prior to uploading into the EHR. MR/AD stated private information about Residents 6, 17, 24, 40 and 41 could have been given to the wrong providers or facilities. MR/AD stated when Residents 6, 17, 24, 40 and 41's health information was found in Resident 15's EHR it was a Health Insurance Portability and Accountability Act (HIPAA - A law that is meant to keep your personal medical information private and secure) violation.During a concurrent interview and record review on 5/21/26 at 4:03 p.m. with the Director of Nursing (DON), Resident 15's EHR document titled, Annual H&P Examination, dated 12/28/25, was reviewed. Resident 15's Annual H&P Examination included H&P's that belonged to Residents 6, 17, 24, 40 and 41. The DON stated prior to giving MR documents for a resident, she would ensure the documents were for the correct resident. The DON stated Residents 6, 17, 24, 40 and 41 H&Ps were uploaded into Resident 15's EHR and should not have been. The DON stated her expectation was that medical records should be placed into the correct resident's chart. The DON stated it was important to ensure that information in a resident's chart is correct because medications, orders or treatments could be missed or performed on the wrong resident. The DON stated when Residents 6,17, 24, 40 and 41's health records were in Resident 15's EHR that was a HIPAA violation.During a review of the facility's job description (JD) titled Medical Records Clerk, dated 2023, the JD indicated, .Major Duties and Responsibilities.Ensures resident health information is protected.Additional Tasks.Maintains confidentiality and protected health information, including verbal, written, and electronic communications.During a review of the facility's policy and procedure (P&P) titled Documentation in Medical Record, dated 2026, the P&P indicated, Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure sterile water bottles used for oxygen humidification were labeled with the open date for one of 32 residents (Resident 35) observed receiving oxygen therapy. This failure had the potential to result in the use of contaminated respiratory equipment and increased the risk of infection. Findings:During an interview on 5/19/26 at 9:36 a.m. in Resident 35's room, Resident 35 stated he had been admitted to the facility approximately six days prior. Resident 35 was observed wearing a nasal cannula connected to an oxygen concentrator and stated he had not used oxygen prior to admission, but used it at the facility as needed. The sterile water bottle attached to the oxygen concentrator for humidification was not labeled with the date opened. During a review of Resident 35's admission Record (a summary of important information regarding a patient which include patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated, Resident 35 was admitted to the facility on [DATE] with a diagnosis which included chronic obstructive pulmonary disease (COPD-a chronic lung disease that made it difficult to breath due to damaged airways and reduced airflow in the lungs), atelectasis (a condition in which part of the lung did not fully expand with air, making it harder to breath normally), congestive heart failure (a condition in which the heart did not pump blood effectively, which could cause fluid buildup in the lungs and body) and dependence on renal dialysis (a machine treatment that cleaned waste and extra fluid from the blood when the kidneys were no longer working properly. Dependence on renal dialysis meant the resident relied on this treatment to survive). During a review of Resident 35's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 35's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 indicated Resident 35 had no cognitive deficits. During a record review of Resident 35's Order Summary Report (OSR), dated 5/15/26, the OSR indicated Resident 35 had an order for oxygen therapy to change concentrator bottles on oxygen bottles as needed. During an interview on 5/20/26 at 3:10 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated nasal cannulas were changed during night shift and sterile water bottles used for oxygen humidification were replaced weekly or as needed. LVN 1 stated cannulas and sterile water bottles were dated and timed when changed, this was a standard Medication Administration Record (MAR) order, and replacement was part of Sunday night shift nursing duties. LVN 1 stated an unlabeled sterile water bottle should be replaced and labeled, and failure to do so increased the risk of infection. During an interview on 5/21/26 at 12:04 p.m. with the Infection Preventionist (IP), the IP stated oxygen humidification equipment was changed weekly, typically by respiratory therapy, and Resident 35 used oxygen daily. The IP stated the nasal cannula and sterile water bottle should be replaced and dated when changed. The IP stated dating was important to prevent contamination and that an undated sterile water bottle should be discarded and replaced due to infection control concerns. During an interview on 5/22/26 at 12:03 p.m. with the Director of Nursing (DON), the DON stated her expectation was for sterile water bottles used for oxygen humidification to be dated when opened and changed when due. The DON stated dating the bottle was important so staff would know how long it had been in use and whether it remained appropriate for continued resident use. The DON stated an opened bottle without a date created an infection control concern, as staff could not determine whether the sterile water was still safe for use. During a review of the facility's policy and procedure (P&P) titled, Respiratory Therapy Equipment Cleaning and Replacement Policy, dated 1/1/2026 the P&P indicated, 2. Equipment replacement schedule: daily (every 24 hours) bubble humidifiers (for all patients receiving oxygen therapy).4 labeling requirements all equipment that is issued, cleaned or replaced must be labeled (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clearly with: patient full name, room number, issue date, change date (issue date + 7 days, labels must be legible and updated immediately after each change.staff must verify labeling accuracy at the time of change.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration , dated 2026 the P&P indicated, change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer.