STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure the physician reviewed and took timely action on a medication regimen review (MRR, consists of a thorough evaluation of the medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) irregularity (includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy) identified by the facility's pharmacy consultant for three of five sampled residents (Residents 1, 7, and 9) reviewed for unnecessary medications by failing to ensure:Resident 1's March 2026 MRR was addressed by the physician for the use of Benadryl (Diphenhydramine, medication used to relieve allergy symptoms and sometimes to aid sleep).Resident 7's MRR recommendations for appropriate side effect (an unintended or secondary effect) monitoring on 2/16/2026 and 3/17/2026 were followed up on and/or carried out for the medication lamotrigine (Lamictal- anticonvulsant [a medication used to prevent or treat seizures- a sudden disruption of the brain's normal electrical activity accompanied by altered consciousness and/or other neurological and behavioral manifestations] and mood stabilizer).Resident 9's MRR recommendation was addressed by the physician for the use of Ergocalciferol (a dietary supplement and medication used to treat and prevent vitamin D deficiency, helps the body absorb calcium and phosphorous to build strong bones).These deficient practices increased Residents 1, 7, and 9's risk to experience adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to their medication therapy, potentially leading to impairment or decline in their mental, functional, and psychosocial wellbeing.Findings: 1. During a review of Resident 1's admission Record, the admission record indicated Resident 1 was admitted to the facility on [DATE], with the diagnoses including but not limited to chronic obstructive pulmonary disease (COPD, disease that causes obstructed airflow from the lungs), schizoaffective disorders (a mental illness that causes loss of contact with reality), and schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves). During a record review of Resident 1's Order Summary Report, dated 3/16/2026, the order indicated Benadryl allergy oral tablet 50 milligrams (mg, unit of measurement) by mouth at bedtime for pruritis (itching). During a record review of the Consultant Pharmacist's Medication Regimen Review, dated 3/17/2026, the MRR indicated Resident 1 had an order for Benadryl at bedtime for pruritis. The MRR also indicated that Diphenhydramine, due to its anticholinergic (a substance or drug that blocks the action of acetylcholine, a chemical messenger in the body, reducing certain involuntary body functions) properties, such as dry mouth, blurred vision, urinary retention (condition that makes it difficult to (continued on next page)

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

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	empty the bladder, either partially or completely), etc., this agent is not recommended for use in the elderly population. The MRR further indicated to assess current regimen for a term of therapy (i.e. short-term use), and should current regimen continue to be clinically warranted, suggest documenting an assessment of risk versus benefit in your notes, or on this form, describing that it continues to be appropriate therapy for this resident. During a record review of Resident 1's Minimum Data Set (MDS, a resident assessment and tool), dated 3/19/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) for upper body dressing, roll left and right, and sit to lying. During a concurrent interview with the Director of Nursing (DON) and record review of Resident 1's progress notes and MRR on 5/7/2026 at 3:13 PM, the DON stated Resident 1's MRR for 3/17/2026 was not addressed. The DON stated Resident 1's progress notes did not indicate that the physician was notified and/or that any follow^up occurred regarding Resident 1's MRR. The DON stated the MRR should have been addressed within 72 hours of 3/17/2026. The DON further stated following up with the physician on the pharmacist's MRR recommendation was important to ensure Resident 1 received the right medication dosage, and if the medication was no longer needed, it would be discontinued accordingly. 2. During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility with diagnoses that included schizophrenia, hemiplegia and hemiparesis on the right side of the body and gastro-esophageal reflux disease. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7 had severely impaired cognitive skills for daily decision making. The MDS also indicated that Resident 7 required partial moderate assistance with oral and personal hygiene and dependent with toileting hygiene, self-bathing/showering, and lower body dressing. During a review of Resident 7's Order Summary Report, the Order Summary Report indicated lamotrigine oral tablet 100 mg and 25 mg, give one tablet (of each to total [=] 125 mg) by mouth at bedtime for mood disorder manifested by angry outbursts. During a concurrent interview and record review on 5/7/2026 at 1:31 PM with the DON, the Consultant Pharmacist's MRRs, dated 2/19/2026 and 3/17/2026, were reviewed. The MRRs indicated that Lamictal was classified as an anticonvulsant (), with a side effect profile that was different from the side effect profile of an antipsychotic (a medication primarily used to manage psychosis [a severe mental condition in which thought, and emotions are so affected that contact is lost with reality]). The MMR further indicated for the side effect monitoring of Lamictal to be updated to more accurately reflect the side effect profile (i.e., as an anticonvulsant). The DON stated MRRs are completed monthly and the pharmacy recommendations are carried out by the doctors and nursing staff. During the same concurrent interview and record review on 5/7/2026 at 1:31 PM with the DON, Resident 7's electronic chart was reviewed for the period of 2/19/2026 through 5/7/2026. Resident 7's electronic chart failed to indicate anticonvulsant side effect monitoring for lamotrigine or documentation on why the recommendation for anticonvulsant side effect monitoring was not being done. The DON stated that no anticonvulsant side effect monitoring was being completed for Resident 7 and that the recommendation was not followed. The DON stated that lamotrigine is an (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anticonvulsant and it was inappropriate to continue monitoring for antipsychotic side effects because the side effects of anticonvulsants and antipsychotics may differ. The DON further stated that it was important to follow through with the pharmacist's recommendations for anticonvulsant side effect monitoring to ensure the appropriate side effects are monitored, prevent potential harm to the resident, and identify any changes in Resident 7's condition. 3. During a review of Resident 9's admission Record, the admission Record indicated the facility initially admitted Resident 9 on 6/3/2024 and readmitted on [DATE] with diagnoses including, but not limited to protein calorie malnutrition (a severe life threatening condition caused by a lack of enough calories and protein in the diet resulting in weight loss, weak immunity, and reduced functional capacity), osteoporosis (a common bone disease that makes bones weak, brittle, and porous significantly increasing the risk for fractures [break in bones]), and dementia (a progressive state of decline in mental abilities). During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 9 was independent (Resident completes the activity by himself with no assistance from a helper) with eating, oral and toileting hygiene, and upper body dressing. The MDS indicated Resident 9 required set up or clean up assistance (Helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) with lower body dressing, putting on/taking off footwear and personal hygiene. The MDS further indicated Resident 9 required supervision or touching assistance (Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently) with shower/bathing self. During a review of the Consultant Pharmacist's MRR, dated 3/17/2026, the MRR indicated Resident 9 was on Ergocalciferol 50,000 units (measurement of a medication's biological activity or effect than its physical weight, used to standardize the potency of vitamins, hormones, or certain drugs) weekly. The most recent Vitamin D level was more than (>) 150 (high), which was drawn on 12/10/2025. The MRR indicated the pharmacist's recommendation to consider discontinuing the order at this time since laboratory results have normalized and high dose therapy may no longer be warranted. During a review of Resident 9's Order Summary Report, dated 5/7/2026, the Order Summary Report indicated Ergocalciferol oral capsule 1.25 milligram (mg, a unit of measurement for drug dosage equal to one-thousandth of a gram) (50000UT), give one capsule by mouth one time a day every Tuesday for supplement, with order date of 12/15/2025. During a concurrent interview and record review on 5/7/2026 at 3:27 PM, with the DON, Resident 9's progress notes and MRR dated 3/17/2026, were reviewed. The DON stated there was no physician notification documented in the progress notes addressing Resident 9's MRR. The DON stated the physician was not notified and should have been, within 72 hours after the MRR was done on 3/17/2026. The DON stated that not following the MRR recommendations for Resident 9 could result in an increased calcium (a vital mineral that the body needs to build and maintain strong bones and teeth) level, cause nausea (urge to vomit), vomiting (forceful, involuntary expulsion of stomach contents through the mouth), and weakness for Resident 9. The DON further stated that following up with the physician regarding MRR recommendations is important to ensure residents receive the right dosage of medications and determine if medications need to be discontinued. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's Policy and Procedure (P&P) titled, Medication Regimen Reviews, dated 1/29/2026, the P&P indicated upon receiving the MRR from the pharmacist, the attending physician reviews and responds to the report. The physician documents in the resident's medical record that the pharmacist's recommendations have been reviewed and what (if any) actions were taken to address them. If the physician does not provide a timely or adequate response, or the consultant pharmacist identifies that no action has been taken, he/she contacts the medical director or (if the medical director is the physician of record) the administrator.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to follow proper food handling practices in accordance with its policy and procedure (P&P) by failing to:a. Label food in the kitchen with item name and use by date (the last date recommended for the use of the product) and/or open date.b. Keep the refrigerator temperature log updated every shift.c. Discard expired food items in the kitchen.d. Ensure kitchen floor was clean and dry when water overflowed from dishwashing machine onto the floor.e. Ensure the ice machine's drainpipe had an air gap (physical separation between a water supply outlet and the flood-level rim of a receiving vessel like a sink or drain). These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization.Findings: During a concurrent interview and observation on 5/4/2026 at 7:59 AM with the [NAME] (CK) in the kitchen, CK stated the meat in the refrigerator was only labelled with the received on 4/30/2026 and use by date of 4/30/2026. CK stated CK had pulled out the ground beef on 5/3/2026 and forgot to label the food item with name and the use by date of 5/5/2026 since it was being thawed in the refrigerator. During a concurrent interview and record review on 5/4/2026 at 7:59 AM with the Dietary Supervisor (DS) of the Refrigerator Temperature Log for the month of May 2026, DS stated staff were supposed to check the refrigerator temperatures in the morning and afternoon and document the temperature on the log. DS stated the morning temperatures for 5/3/2026 and 5/4/2026 were missing. During a concurrent interview and observation on 5/4/2026 at 8:24 AM with DS, DS stated the mashed potatoes on the kitchen counter had a use by date of 4/31/2026. DS informed CK the mashed potatoes needed to be discarded. During a concurrent interview and observation on 5/4/2026 at 8:37 AM with Dietary Aide (DA), the kitchen floor was observed to be wet with a puddle of water. DA stated the floor gets wet when she washes the dishes in the sink. There was more puddling observed on the kitchen floor when the washing machine strainer was overspilling water and leaking onto the floor. During a concurrent interview and observation on 5/4/2026 at 8:45 AM with DS, DS stated the kitchen floor was wet with water. DS stated water was coming out from the strainer of the washing machine.During a concurrent interview and observation on 5/5/2026 at 2:31 PM with Maintenance Supervisor (MS) of the ice machine, MS stated the ice machine drainage pipe was going directly into the floor and did not know how deep the tube extended past the floor. MS stated the ice machine drainpipe was supposed to have an air gap and there was no air gap since the pipe went through the floor. MS stated an air gap was needed to prevent backflow of bacteria back into the ice machine. During an interview on 5/5/2026 at 2:41 PM with DS, DS stated food items should be labelled with product name and use by date. DS stated when food was thawed, the guideline was for the food item to be labeled and used by the third day. DS stated any food beyond the use by date needed to be discarded due to the growth of germs and bacteria. DS stated the bacteria on the food could harm the residents and staff in the facility. DS stated the kitchen floor should not have pooled water and could cause a safety hazard to the staff. During an interview on 5/6/2026 at 1:43 PM with DS, DS stated the water mopped up from the kitchen floor was discarded in the same utility room shared with housekeeping. During an interview on 5/6/2026 at 5:15 PM with the Infection Prevention Nurse (IPN), IPN stated the food and/or utensils could become contaminated from splatters of water on the floor when there was an overflow of water from the washing machine onto the kitchen floor. IPN stated residents could experience food poisoning or food illness from the splatters of water from the floor. IPN also stated that since there was no water drainage system the water on the floor can become stagnant which could support the growth of bacteria. During a record review of the facility's P&P titled, Refrigerators and Freezers, dated 1/26/2026, the P&P indicated monthly tracking sheets for all refrigerators and freezers are (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	posted to record temperatures; monthly tracking sheets include refrigerator temperature, temperature of food, initials, and action taken; use by dates are completed with expiration dates on all prepared food in refrigerators; expiration dates on unopened food are observed and use by dates are indicated once food is opened; supervisors are responsible for ensuring food items in pantry, refrigerators, and freezer are not past use by or expiration dates. During a record review of the facility's P&P titled, Sanitization, dated 1/26/2026, the P&P indicated the food service area is maintained in a clean and sanitary manner and all kitchens, kitchen areas and dining areas are kept clean. During a record review of the facility's P&P titled, Water Supply, dated 1/29/2026, the P&P indicated approaches to controlling waterborne microorganisms (i.e., water system decontamination) will be consistent with the Food and Drug Administration (FDA). During a record review of the 2022 FDA 2022 Food Code 2022, 5-202.13 titled, Backflow Prevention, Air Gap, indicated an air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less then 22 millimeters (mm, unit of measurement) (one inch). https://www.fda.gov/media/164194/download?attachment

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure garbage was properly disposed of in accordance with the facility's policy and procedure (P&P) titled, Food-Related Garbage and Refuse Disposal. This deficient practice had the potential to attract pests and rodents and may cause disease and other health issues to residents, staff, and the community.Findings: During a concurrent observation and interview on 5/4/2026 at 8:30 AM with the Dietary Supervisor (DS), in the facility's parking lot, two dumpsters were overfilled with trash bags and left uncovered. DS stated the two dumpsters were overfilled with trash bags and were supposed to be covered with lids. DS stated the dumpsters should be covered with lids to prevent infection control. During a record review of the facility's P&P titled, Food-Related Garbage and Refuse Disposal, dated 1/26/2026, the P&P indicated outside dumpsters provided by garbage pickup services will be kept closed and fee of surrounding litter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility staff failed to obtain an accurate water temperature reading and ensure the water used to wash one load of soiled linens (bedsheets, pillowcases and blankets) were washed at 160ˆ for a minimum of 25 minutes Washer two (2) as indicated in the facility's policy. This deficient practice had the potential to compromise infection control measures to eliminate disease causing germs (microscopic [extremely small and invisible to the naked eye], living organisms including bacteria, viruses, fungi, and protozoa) on linens which could get residents sick and potentially spread infection in the facility.Findings:During a concurrent observation and interview on 5/6/2026 at 11:36 AM with Laundry Staff 1 (LS 1) at the laundry room washer area, one wash load of linen was observed running in Washer 2. LS 1 stated the temperature reading on the thermometer attached to the hot water line behind Washer one (1) and Washer 2 was at 120 degrees Fahrenheit (ˆ-temperature scale used to measure how hot or cold something is). LS 1 stated he does not know why the temperature reading behind Washers 1 and 2 was at 120 ˆ which is lower than the temperature reading on the water heater gauge was set at 160 ˆ. LS 1 stated the temperature readings from the thermometer attached to the hot water line behind Washer 1 and 2 and water heater gauge should be the same. LS 1 stated the facility Washers 1 and 2'stemperature and should be at 160 ˆ. During a concurrent observation, interview, and record review on 5/6/2026 at 12:13 PM with Maintenance Supervisor (MS) and LS 1 in the laundry room dryer area, the dyer temperature log for 5/2026 was reviewed. The dryer temperature log indicated recorded temperatures for Dryer 1 and Dryer 2 from 5/1/2026 to 5/6/2026. LS 1 stated Dryer 1 did not have a built-in thermometer to check the dryer temperature. LS 1 stated the dryer has three settings of low, medium, or high temperature button and he does not know the time (duration the dryer will run) and temperature settings for each selection. LS 1 stated he copied and wrote the temperature readings for Dryer 1 from previous logs as instructed by the previous MS. LS 1 stated staff had been recording the temperature for Dryer 1 without actually measuring it. MS confirmed with LS 1 that temperature was not measured for Dryer 1 because there was no thermometer or temperature gauge to measure Dryer 1's temperature. MS and LS 1 stated recording the temperature without measuring the temperature for Dryer 1 was not acceptable and was not accurate. During a concurrent observation and interview on 5/6/2026 at 1:07 PM with the MS and LS 1 in the laundry room washer section, a laundry cycle for soiled linens were started using Washer 2. MS confirmed the thermometer reading from the hot water line going to Washers 2 was 120ˆ. During a concurrent observation and interview at 5/6/2026 at 1:13 PM at the boiler room with the MS, water heater temperature control panel was set at 160ˆ and confirmed by MS. The hot water temperature reading on the water heater thermometer (gauge) was at 148ˆ. During a concurrent observation and interview on 5/6/2026 at 1:20 PM, in the laundry room washer area, temperature reading from the hot water line leading to Washers 1 and 2's thermometer was at 120ˆ. MS stated the temperature gauge on the water heater in the boiler room and the thermometer attached to the hot water line of Washers 1 and 2 were not working as it was not reading the same temperature. During a concurrent observation and interview on 5/6/2026 at 1:32 PM in the boiler room, water heater gauge reading was at 160ˆ per MS. MS stated the temperature of 160ˆ was not maintained for at least 25 minutes from the start of the wash cycle at 1:07 PM to 1:32 PM because at 1:20 PM the thermometer behind Washer 2 indicated a temperature of 120ˆ. MS stated this was not acceptable as the temperature was not enough to kill the germs in the linens. During a concurrent interview and record review on 5/6/2026 at 4 PM with Infection Prevention and Control Nurse (IPN), the policy and procedure (P&P) titled Departmental (Environmental Services)-Laundry and Linen, revised 1/26/2026 was reviewed. The IPN stated that the P&P indicated that for high-temperature processing, wash linens in water that is at least 160ˆ, for a minimum or 25 minutes. The IPN stated that P&P was not followed when water temperatures from the thermometer behind Washer 1 and 2 OR water line leading to Washers 1 and 2 was observed to be (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	below 160 ˆ. IPN stated on the water temperature observed on 5/6/2026 was 120ˆ at 1:07 PM 148ˆ, at1:13 PM 120ˆ at1:20 PM , and 160ˆ) at 1:32 PM. IPN stated the water temperature for Washer 1 and 2 was not at 160ˆ as soon as the wash cycle started and was not maintained at 160IPN stated this was not acceptable as the temperature and time were not enough to adequately and effectively sanitize the linens used by the residents and could place the residents at risk for infections and spread of infections. During an interview on 5/7/2026 at 9 AM with the Administrator (ADM), the ADM stated there was no specific facility P&P addressing washer and dryer outlining details of temperature and time settings for laundry and documentation or logging of temperatures for washers and dryers. The ADM stated there should be a P&P for this so laundry and maintenance departments will be guided by set standards to effectively manage infection control measures in terms of laundry of linensDuring a review of the P&P titled Laundry and Bedding, Soiled, reviewed 1/29/2026, indicated soiled laundry/bedding shall be handled, transported, and processed according to best practices for infection prevention and control.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that advance directives (a legal document indicating resident preference on end-of-life treatment decisions) were discussed and written information was provided to one (1) of 1 sampled resident (Resident 7) reviewed for advance directive. This deficient practice violated Resident's 7 and/or the resident's responsible party's (RP) right to be fully informed of the option to formulate their advanced directives and had the potential to cause conflict with the residents' wishes regarding health care.Findings:During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body)on the right side of the body and gastro-esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus). During a review of Resident quarterly Minimum Data Set (MDS- a resident assessment tool), dated 4/3/2026, the MDS indicated Resident 7 had severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated, Resident 7 was assessed to need partial moderate assistance (helper does less than half the effort) with oral and personal hygiene and dependent with toileting hygiene, self-bathing/showering and lower body dressing. During a concurrent interview and record review on 5/6/2026 at 10:31 AM with the Director of Nursing, Resident 7's Advance Healthcare Directive (AHCD) Acknowledgment Form, dated 3/3/2026 was reviewed. The AHCD Acknowledgment form did not indicate the following:Resident 7's RP received information regarding the right to make an AHCD.If Resident 7 does or does not have an AHCD.If Resident 7's RP did or did not want information regarding formulating an AHCD.The DON stated the AHCD Acknowledgment form should have been completed upon admission of Resident 7 to the facility for staff to know if Resident 7 had an advance directive and that information to formulate an AHCD was given to Resident 7's RP, per facility policy. During an interview on 5/6/2026 at 12:11 PM with the Social Services Director (SSD), the SSD stated per facility protocol, the AHCD Acknowledgement form needs to be completed and signed by the resident or RP with their selection to know if the resident has an advance directive, and or wants additional information to make one so that the resident's wants or wishes with regard to the end-of-life treatment will be known to the staff. During a review of the facility's policy titled Advance Directives, dated 1/29/2026, the policy indicated the resident has the right to formulate an advance directive, and advance directives are honored in accordance with state law and facility policy. The policy also indicated the following:Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives.The resident or representative is provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so.Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advance directive is provided in a manner that is easily understood by the resident or representative.If the resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the residents' legal representative.Information about whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician regarding the change of condition (COC, tool used by health care professionals when communicating about critical changes in a resident's status) of weight loss for one (1) of two (2) sampled residents (Resident 3) reviewed under nutrition. This deficient practice had the potential to result in delayed provision of necessary care and services.Findings:During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE], with the diagnoses including but not limited to protein-calorie malnutrition (a severe condition resulting from inadequate intake of protein and/or calories), thrombocytopenia (abnormally low number of platelets in the blood), and dementia (progressive brain disorder that slowly destroys memory and thinking skills). During a record review of Resident 3's Care Plan, dated 10/20/2025, the Care Plan indicated Resident 3 was at risk for alteration in nutritional status due to being on medication that may alter appetite, malnutrition, needed assistance with meals, and dementia process. The Care Plan goal was Resident 3 will maintain adequate nutrition status as evidenced by stable weight with no significant weight changes (significant weight change defined as greater than or equal to five [5] percent in 30 days, greater than or equal to 7.5 percent in 90 days). The Care Plan interventions for staff were to weigh residents per policy, notify the physician of changes, and monitor weights and refer to weight variance committee if significant change occurs. During a record review of Resident 3's Minimum Data Set (MDS, a resident assessment and tool), dated 4/30/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) on eating, toileting hygiene and sitting to lying on the bed. The MDS also indicated Resident 3 did not have a loss of 5 percent or more in the last month or ten (10) percent or more in the last six (6) months. During a record review of Resident 3's Weight Summary dated from 4/1/2026 to 5/4/2026 indicated as follows:On 4/1/2026 the resident's weight was 123.0 pounds (lbs).On 5/4/2026 the resident's weight is 116.0 lbs (-5.69 % weight loss, seven [7] lbs weight loss on 30 days) During a concurrent interview and record review on 5/6/2026 at 9:45 AM with Restorative Nurse Aide 1 (RNA 1), Resident 3's Weight Summary dated from 4/1/2026 to 5/4/2026 was reviewed. RNA 1 stated according to the weight summary, Resident 3 lost 7 lbs within the last month. RNA 1 stated RNAs are responsible for obtaining the resident's weights and to notify the charge nurse when there was a weight loss of five lbs or more.\. RNA 1 stated he did not inform the charge nurse of Resident 1's 7 lbs weight loss noted when he took and recorded Resident 3's weight after 5/4/2026 and should have informed the charge nurse. RNA 1 stated the charge nurse should have been informed to assess the resident for the weight loss and to notify the physician. During a concurrent interview and record review on 5/6/2026 at 10:35 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 3's COC and Nurses Progress Notes dated from 5/4/2026 to 5/6/2026 were reviewed. The COC and progress notes did not have documented evidence that Resident 3's 7 lbs weight loss was assessed, monitored and that the physician was notified. LVN 1 stated the physician needed to be notified immediately when residents experienced a weight loss of four lbs or more in a month since it was a change in the resident's condition. LVN 1 stated there were no notifications to the physician regarding Resident 3's weight loss. During an interview on 5/7/2026 at 2:42 PM with the Director of Nursing (DON), the DON stated the physician should be notified right away when there was a weight loss of three (3) lbs or more within 30 days. The DON stated the facility should have started taking action to prevent any further weight loss and decline of the resident. During a record review of the facility's Policy and Procedure (P&P) titled, Change in a Resident's Condition or Status, dated 1/26/2026, the P&P indicated the nurse will notify (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's attending physician or physician on call when there has been a significant change in the resident's physical/emotional/mental condition. The P&P also indicated notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status. During a record review of the facility's P&P titled, Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, dated 1/26/2026, the P&P indicated the staff will report the physician significant weight gains or losses or any abrupt or persistent change from baseline appetite or food intake.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 25) reviewed for beneficiary notification was informed of the changes in Medicare (federal health insurance program) coverage and provided with the Advanced Beneficiary Notice (ABN, written notice provided to Medicare beneficiaries when Medicare payment is expected to be denied for certain services or items) in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to result in Resident 25's Responsible Party (RP) not being able to exercise their right to file an appeal and had the potential to cause stress to the resident's RP for not being able to make adequate arrangements for charges that may be incurred. Findings:During a review of Resident 25's admission Record, the admission Record indicated Resident 25 was admitted to the facility on [DATE], with the diagnoses including but not limited to encephalopathy (brain disease, damage, or malfunction that results in an altered mental state), Alzheimer's disease (a brain disorder that destroys memory and other important mental functions), and dementia (progressive brain disorder that slowly destroys memory and thinking skills). The admission Record also indicated Resident 25 had RP as the decision maker. During a review of Resident 25's Minimum Data Set (MDS, a resident's assessment tool), dated 2/1/2026, the record indicated Resident 25's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were severely impaired. During a review of Resident 25's Skilled Nursing Facility (SNF) Beneficiary Notification Review form completed on 3/13/2026, the form indicated Resident 25's Medicare Part A Skilled Services episode started on 1/5/2026 and the last day covered day of Part A Service ended on 3/16/2026. The form indicated SNF ABN Form was not provided to Resident 25's RP. During an interview on 5/6/2026 at 11:25 AM with the Business Office Manager (BOM), BOM stated she called Resident 25's RP once on 3/13/2026 to discuss the resident's Part A coverage that will end on 3/16/2026 and left voice message. BOM stated she did not follow up and forgot to call Resident 25's RP again. BOM stated she did not send a copy of the SNF ABN to Resident 25's RP. BOM stated Resident 25 was a long-term resident and had resided in the facility since 1/18/2024 and there was no address for Resident 25's RP on file. BOM stated there should have been an address on file to send the information to the RP. During a follow-up interview on 5/6/2026 at 12:17 PM with BOM, BOM stated the SNF ABN notification via mail to Resident 25's RP would notify Resident 25's RP if there was an out of pocket that was not covered so Resident 25's RP could prepare for the financial responsibility or file an appeal if they did not agree with the decision. BOM stated it was not provided to Resident 25's RP. During a review of the facility's P&P titled, Advance Beneficiary Notice, dated 1/26/2026, the P&P indicated written notices of the likelihood of Medicare payment denial are provided to the resident/beneficiary as soon as the facility makes the assessment that Medicare payment certainly or probably will not be made and before the item or service is furnished.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide Restorative Nursing Services (a program available in nursing homes to help residents maintain any progress made during therapy treatments, enabling them to achieve their highest practicable level of functioning) treatments (total of 10 missed treatments) for one of two sampled residents (Resident 3) reviewed for limited range of motion (ROM, full movement potential of a joint) in accordance with the physician's order. This deficient practice placed Resident 3 at risk for decline in physical functions and develop contractures (condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in the extremities (a limb of the body, such as the arm or leg) for not receiving the ordered exercises. Findings:During a review of Resident 3's admission Record, the admission record indicated Resident 3 was admitted to the facility on [DATE], with the diagnoses including but not limited to muscle wasting (loss of muscle mass) and atrophy (muscle shrinking), contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) in the left knee, left shoulder, right shoulder, left elbow and right elbow. During a record review of Resident 3's Joint Mobility Screening, dated 1/20/2026, the screening indicated Resident 3's right and left knees had severe (greater than 50 % loss) loss of mobility. It also indicated Resident 3's right elbow had severe (greater than 50 % loss) loss of mobility and Resident 3's left elbow had moderate (26-50 % loss) loss of mobility. The screening also indicated the current program (RNA program) effectiveness had maintained joint mobility. During a record review of Resident 3's Care Plan, dated 2/7/2026, the Care Plan indicated Resident 3 had an alteration in joint mobility as evidenced by limitations noted to right and left elbow, right and left hip, right and left knee, left wrists, left fingers and was at risk for further unavoidable decline in range of motion. The Care Plan indicated one of the interventions was for staff to provide range of motion exercises as ordered and position the resident to prevent further contractures with pillow or splint. During a record review of Resident 3's Minimum Data Set (MDS, a resident assessment and tool), dated 4/30/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was severely impaired. The MDS indicated Resident 3 had impairment on both sides in the upper and lower extremities. The MDS also indicated Resident 3 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) for toileting hygiene, oral hygiene, upper and lower dressing, roll left and right, sit to lying. During a record review of Resident 3's Order Summary Report for the month of May 2026, the order summary report indicated the following: On 2/9/2026- RNA to apply splint (device used to immobilize, protect, and support injured or fractured bones and joints) to both knees, every day five (5) times a week, for four (4) hours or as tolerated.On 3/24/2026- RNA Program, passive range of motion (PROM, the range that can be achieved by external means such as another person or a device) exercises to both upper extremities (UE: shoulders, elbows, wrists, hands) and lower extremities (LE: hips, knees, ankles, and feet) in all planes as tolerated. Every day 5 times a week. During a record review of Resident 3's Joint Mobility Screening, dated 4/28/2026, the screening indicated Resident 3's right and left knees had severe loss of mobility. It also indicated Resident 3's right elbow had severe loss of mobility and Resident 3's left elbow had minimal (less than 25 % loss) loss of mobility. The screening also indicated the current program effectiveness had improved. During a record review of Resident 3's Documentation Survey Report for the months of March and April 2026, it indicated Resident 3's order for RNA services for PROM exercises in both UE and LE in all planes as tolerated every day 5 times a week. It also indicated the order for RNA to apply splints to both knees every day 5 times a week for 4 hours or as tolerated. The documentation survey report indicated 10 missed treatments for the following weeks of the months of March and April 2026: Week 2: 3/9/2026 to 3/15/2026 (three (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	missed treatments)Week 3: 3/16/2026 to 3/22/2026 (three missed treatments)Week 4: 3/23/2026 to 3/29/2026 (one missed treatment)Week 5: 3/30/2026 to 4/5/2026 (one missed treatments) Week 6: 4/6/2026 to 4/12/2026 (one missed treatments) Week 7: 4/13/2026 to 4/19/2026 (one missed treatments) During a concurrent interview and record review on 5/6/2026 at 9:09 AM with Restorative Nurse Aide 1 (RNA 1), Resident 3's Documentation Survey Report for the month of March and April 2026 were reviewed. RNA 1 stated according to the documentation survey report there were 10 missing treatments or RNA services for the month of March and April 2026. RNA 1 stated Resident 3 was supposed to receive RNA services for PROM exercises to both UE and LE and knee splints for both knees. RNA 1 stated RNAs needed to document after performing the RNA services for the resident. RNA 1 stated there were no notes indicating the reasons for the missed RNA services. RNA 1 stated when there was no charting done for the RNA services, then it meant that the RNA services were not provided for Resident 3. RNA 1 stated when RNA services were not done for Resident 3, the resident could get more contracted and/or the contractures could worsen. During a concurrent interview and record review on 5/6/2026 at 10:51 AM with Director of Rehabilitation (DOR) of Resident 3's Joint Mobility Screening, DOR stated according to the resident joint mobility screening, Resident 3 had multiple contractures. DOR also stated RNA services being performed in accordance with the physician's order were needed to maintain the resident's joints and to have a better quality of life. During an interview on 5/7/2026 at 2:39 PM with the Director of Nursing (DON), the DON stated RNAs needed to document the completion of the RNA services or treatments provided to the residents. The DON stated if there was no documentation for RNA services, then it meant the RNA treatment was not done for the resident. The DON stated the importance of providing RNA services as ordered was to improve the resident's activities of daily living and functionality and prevention of contractions. The DON stated when RNA services were not provided to the residents there could be a decline in activities of daily living which can lead to muscle wasting and contractures. During a record review of the facility's Policy and Procedure (P&P) titled, Restorative Nursing Services, revised 7/2017, the P&P indicated residents will receive restorative nursing care as needed to help promote optimal safety and independence. The P&P also indicated restorative goals may include but are not limited to supporting and assisting the resident in maintaining his/her dignity, independence and self-esteem and participating in the development and implementation of his/her plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 follow its policy to develop and implement a care plan that included strategies and interventions to maintain the safety for one of three sampled residents (Resident 36), reviewed for accidents and assessed as at risk for elopement (the act of leaving a facility unsupervised and without prior authorization) /wandering (moving without any clear purpose or direction). This deficient practice resulted in Resident 36 wandering into Resident 28's room on 5/4/2026, which had the potential to result in harm and injury to both residents.Findings: During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), unspecified psychosis (a mental health condition characterized by a loss of contact with reality, where a person has difficulty distinguishing what is real from what is not), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 36's Elopement Risk Evaluation, dated 4/18/2026, the Elopement Risk Evaluation indicated Resident 36 was at risk for elopement/wandering. It indicated an appropriate intervention was to conduct frequent visual checks. During a review of Resident 36's Minimum Data Set (MDS- a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 36 with severely impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS also indicated Resident 36 was supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral and personal hygiene, substantial/maximal assistance (helper does more than half the effort) with toileting hygiene. During a review of Resident 36's Care Plan titled, Resident is at Risk for/has a Behavior Problem Related to Psychosis/Dementia, dated 4/30/2026, the Care Plan indicated Resident 36 had visual/auditory hallucinations (sensing things such as visions, sounds, or smells that seem real but are not) with an intervention for staff to intervene as necessary to protect the rights and safety of others. During an observation on 5/4/2026 at 9:08 AM, inside Room C, Resident 36 was observed entering the room, and Resident 28 was observed lying in bed asleep. Resident 36 was then observed going next to Resident 28's bedside, picking up a pair of shoes from Resident 28's nightstand, and calling Resident 28 Mr. [NAME], while leaning onto his bed and speaking in his language. During an interview on 5/7/2026 at 10:14 AM with Licensed Vocational Nurse (LVN 1), LVN 1 stated Resident 36 has a behavior of wandering around the facility and asks staff where her son is. During an interview on 5/7/2026 at 11:07 AM with the Director of Staff Development (DSD), the DSD stated Resident 36 was confused due to her dementia and wandered into Room C because she was looking for her son. The DSD stated it was not safe for Resident 36 to wander into Room C because it was a safety issue for both residents that could have resulted in harm. During a concurrent interview and record review on 5/7/2026 at 11:36 AM with the Director of Nursing (DON), Resident 36's electronic medical chart was reviewed from 4/18/2026 through 5/7/2026. The electronic medical chart failed to indicate a care plan developed for Resident 36's behavior of wandering/elopement. The DON stated Resident 36 was assessed to be at risk for wandering/elopement and should have had a care plan developed with interventions that were implemented. The DON stated this was important to ensure Resident 36 did not wander into the rooms of other residents including Resident 28 and for the privacy and safety of the residents. During a review of the facility's P&P titled, Wandering and Elopements, dated 1/29/2026, the P&P indicated the facility will identify residents who are at risk for unsafe wandering and strive to prevent harm. The P&P also indicated when a resident is identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. During a review of the facility's P&P (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Safety and Supervisions of Resident, revised on 1/29/2026, the P&P indicated Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. The P&P also indicated the facility will have an individualized, resident- centered approach to address safety and accident hazards for individual residents and ensure interventions are implemented and documented.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide nutritional care and services for one (1) of two (2) sampled residents (Resident 44) reviewed for nutrition by failing to monitor and document the resident's meal intake in accordance with the care plan.This deficient practice had the potential to place Resident 44 at risk for further weight loss and negatively affect the resident's overall wellbeing. Findings:During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was originally admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), gastro-esophageal reflux disease (GERD - chronic digestive disease where the contents of the stomach refluxes and irritates the esophagus), and metabolic encephalopathy (a broad term for brain dysfunction caused by systemic illness, chemical imbalances, or organ failure rather than direct physical injury). During a review of Resident 44's Nutrition Assessment Form, dated 1/16/2026, the Nutrition Assessment indicated a weight goal range of 125 pounds (lbs) or greater and with a plan to monitor/evaluate the adequacy of Resident 44's oral (PO) intake. During a review of Resident 44's Registered Dietician (RD)/ Interdisciplinary Team (IDT- a coordinated group of experts from several different fields) Weight Review Skin Review, dated 2/6/2026, the RD/IDT Weight Review indicated that Resident 44 had a significant weight loss likely related to variable PO intake, with a plan to monitor/evaluate the resident's adequacy of PO intake. During a review a Resident 44's Care Plan titled, Resident has the Potential Nutritional Problem/Significant Weight Change Related to Mechanically Altered (moist, soft-textured, and finely chopped or ground foods designed to minimize chewing and safely manage dysphagia Diet Regular Pureed (food that has been blended until smooth and creamy), revised 2/11/2026, the Care Plan indicated a goal for Resident 44 to maintain adequate nutritional status. The care plan interventions were to provide, serve diet as ordered, monitor intake, and record each meal. During a review of Resident 44's Minimum Data Set (MDS- a resident assessment tool), dated, 3/25/2026, the MDS indicated Resident 44 had severely impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 44 was setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating, personal and eating hygiene and substantial/maximal assistance (helper does more than half the effort) with shower/bathing self and lower body dressing. The MDS indicated Resident 44 weighed 118 pounds and had swallowing disorder symptoms including coughing or choking during meals or when swallowing meds, holding food in mouth/cheeks or residual food in mouth after meals and loss of liquids/solids from mouth when eating or drinking. During a review of Resident 44's Order Summary Report, the Order Summary Report indicated an order for regular diet- pureed, started 4/3/2026. During a review of Resident 44's Weights and Vitals Summary, the Weights and Vitals Summary indicated had a severe weight loss (a weight loss greater than 10 % in six [6] months), when the resident's weight decreased from 127 pounds (lbs) on 11/3/2025 to 113 lbs on 5/4/2026. During a concurrent interview and record review on 5/7/2026 at 10:09 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 44's Documentation Survey Report, dated April 2026, the Documentation Survey Report failed to indicate Resident 44's amount of PO intake percentage for the following:Breakfast and lunch on 4/7/2026Dinner on 4/12/2026Dinner on 4/13/2026Dinner on 5/16/2026Dinner on 4/23/2026Breakfast and lunch on 4/24/2026Dinner on 4/28/2026LVN 2 stated there was no documented amount of PO intake for Resident 44 on the dates indicated and there should have been. LVN 2 stated staff should have documented Resident 44's daily at each meal to show that staff are monitoring Resident 44's intake as indicated in the care plan because of Resident 44's fluctuating weight and weight loss. LVN 2 also stated staff should monitor Resident 44's intake at every meal to monitor the amount of food she is eating because it could lead to potential nutritional problems including significant weight loss. During an interview on 5/7/2026 at 12:26 PM with the Director of (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing, the DON stated Resident 44's meal intake should have been monitored and documented every shift to prevent further weight loss. During a review of the facility's policy & procedure (P&P) titled, Nutrition (Impaired)/Unplanned Weight Loss- Clinical Protocol, dated 1/26/2026, the P&P indicated that the nursing staff will monitor and document the weight and dietary intake of residents in a format which permits comparisons over time. The P&P also indicated the staff and physician will define the individual's current nutritional status (weight, food/fluid intake, and pertinent laboratory values), monitor nutritional status, an individual's response to interventions and possible complications of interventions. During a review of the facility's P&P titled, Weight Assessment and Intervention, dated 1/29/2026, the P&P indicated a weight loss of 10 % in 6 months was significant and greater then 10 % was severe.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 5) reviewed for tube feeding received gastrostomy tube (GT, a tube inserted through the belly that brings nutrition directly to the stomach) feeding on 5/4/2026 in accordance with the physician's order. This failure had the potential to cause preventable malnutrition (lack of proper nutrition in the body) and/or weight loss for Resident 5.Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility initially admitted Resident 5 on 10/22/2018 and was readmitted on [DATE] with diagnoses that included but not limited to protein calorie malnutrition (a severe life threatening condition caused by a lack of enough calories and protein in the diet resulting in weight loss, weak immunity, and reduced functional capacity), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dementia (a progressive state of decline in mental abilities). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 5 had severely impaired cognitive skills (ability to think, learn, remember, reason, and pay attention) for daily decision making. The MDS indicated Resident 5 was dependent (Helper does all the effort. Resident does none of the effort to complete the activity or the assistance of two or more helpers is required for the resident to complete the activity) with eating, oral/toileting/personal hygiene, shower/bathing self, upper and lower body dressing and putting on/taking off footwear. The MDS also indicated Resident 5 received 51% or more of her nutrition and 501 cubic centimeters (cc, a metric unit of volume equal to 1 milliliter [ml]) through a feeding tube (GT feeding). During an observation on 5/4/2026 at 12:24 PM inside Resident 5's room, Resident 5 was observed lying in bed with tube feeding pump on, and GT feeding was not connected to Resident 5's GT and the GT feeding formula (also known as enteral formula, a specialized liquid nutrition designed to be delivered directly into the stomach or small intestine through a feeding tube) was spilling to the floor. During a concurrent observation and interview on 5/4/2026 at 12:33 PM inside Resident 5's room, Licensed Vocation Nurse 2 (LVN) confirmed Resident 5's GT feeding was switched on, it was not connected to the resident and the GT feeding formula was spilling to the floor. LVN 2 stated he did not know what happened. During a review of Resident 5's Order Summary Report dated 5/7/2026, the Order Summary Report indicated Enteral (delivering food or medicine directly into the stomach or small intestine, usually via a tube, rather than through the mouth or veins) Feed Order:Every shift check tube placement before initiation of formula, medication administration, and flushing tube, order start date on 2/18/2026.Every shift continuous water flush at 45 milliliters (ml-a measurement of volume) per hour for 20 hours per GT via dual pump (enteral feeding and flush pump, a medical device designed to deliver liquid nutrition directly into a patient's stomach while automatically managing fluid needs) to provide 900 ml per day, order start date on 4/1/2026.Every shift Jevity (feeding formula) 1.5 at 50 ml per hour x 20 hours per GT via dual pump to provide 1000 ml/1500 kilocalorie (kcal, a unit of energy measuring how much power food provides to the body) per day. During an interview on 5/7/2026 at 12 PM with LVN 2, LVN 2 stated he last saw Resident 5's GT feeding connected to Resident 5 on 5/4/2026 at 11 AM. LVN 2 stated another nurse (does not know who) disconnected the GT feeding from Resident 5 before a Certified Nurse Assistant (CNA) took resident for her (Resident 5) shower. LVN 2 stated when Resident 5 was back to the resident's room another nurse (does not know who) may have heard the tube feeding pump (also called dual pump) beeping and restarted the GT feeding without checking if the tube feeding was connected securely to Resident 5's GT. LVN 2 stated the nurse did not follow the steps in the policy of checking connections before initiating or restarting GT feeding. LVN 2 stated this placed Resident 5 at risk for not receiving the resident prescribed calories and nutrition that could lead to weight loss. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled Enteral Tube Feeding via Continuous Pump, reviewed 1/21/2026, the P&P indicated the steps in initiating feeding included:Checking the label on the enteral formula against the physician order before administration and the following information:Resident name, ID, and room numberType of formulaRoute of deliveryAccess siteMethod Rate of administration (ml/hr)Verifying placement of tube, attach the administration set to the enteral tube (feeding tube or GT), and press start.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary respiratory care services for one of one sampled resident (Resident 11) reviewed for oxygen by failing to ensure oxygen (O2- a colorless, odorless, and tasteless gas essential for the survival of living things which use it for breathing and respiration) was administered to Resident 11 via nasal cannula (NC- a small plastic tube, which fits into the person's nostrils for providing supplemental O2) according to the physician's order. This deficient practice placed Resident 11 at risk for experiencing complications such as respiratory distress (a condition that occurs when the body needs more O2, resulting in difficulty breathing, rapid breathing, and low blood O2 levels) that can lead to serious illness and/or death.Findings: During a review of Resident 11's admission Record, the admission Record indicated the facility initially admitted Resident 11 on 8/6/2024 and readmitted on [DATE] with diagnosis including, but not limited to hemiplegia (total paralysis on one side) and hemiparesis (partial muscular weakness on one side of the body) of the left side following cerebral infarction (occurs when a blood clot or blockage stops blood from reaching a part of the brain). During a review of Resident 11's Minimum Data Set (MDS-a resident assessment tool) dated 2/11/2026, the MDS indicated Resident 11 had severely impaired cognitive skills (ability to think, learn, remember, reason, and pay attention) for daily decision making. The MDS indicated Resident 11 required partial/moderate assistance (Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with eating and upper body dressing. The MDS indicated Resident 11 required substantial/maximal assistance (Helper lifts or holds trunk or limbs and provides more than half the effort) with oral and personal hygiene and rolling left and right in bed. The MDS further indicated Resident 11 was dependent (Helper does all the effort. The resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated a physician's order, dated 5/1/2026 for continuous O2 at 4 liters per minute (LPM-unit of measurement for oxygen a patient receives) via NC to keep O2 saturation (measurement of the percentage of O2 red blood cells are carrying) above 92%. During an observation on 5/4/2026 at 12:50 PM, inside Resident 11's room, Resident 11 was observed awake, lying in bed without his NC on his nostrils. The O2 concentrator (a medical device that filters surrounding air, removing nitrogen [colorless and odorless gas that makes up 78% of the air we breathe] to deliver concentrated, medical grade O2) was observed powered on and the NC and tubing were inside a clear plastic bag. Resident 11 stated he needed his O2 and it was hard to breathe. During a concurrent observation and interview on 5/4/2026 at 12:51 PM, DSD came to assess Resident 11. DSD was observed checking Resident 11's O2 saturation. DSD stated it was 88%. DSD confirmed that the O2 concentrator was on, but the NC was not on Resident 11's nostrils. DSD stated Resident 11's O2 order was continuous to keep his O2 saturation above 92%. DSD stated Resident 11's NC and tubing was stored inside the plastic bag. The DSD stated the doctor's order to administer continuous oxygen was not followed which placed Resident 11 at risk for change of condition and hospitalization. During a concurrent interview and record review on 5/7/2026 at 10:05 AM with Licensed Vocational Nurse 1 (LVN 1), the physician's order for Resident 11 was reviewed. LVN 1 stated Resident 11's O2 order indicated continuous at 4LPM via NC to keep O2 saturation above 92%. LVN 1 stated he changed the humidifier (a small disposable bottle attached to the O2 concentrator that adds moisture to the dry O2 before it is inhaled by the patient), NC and tubing and put the NC on the Resident's nostrils at 8:30 AM on 5/7/2026. LVN 1 stated after 8:30 AM, Certified Nurse Assistant (CNA) 2 and CNA 3 provided morning care to Resident 11. LVN 1 stated neither CNA 2 nor CNA 3 approached him to remove or reapply the O2 NC to Resident 11. LVN 1 stated it was important to follow the doctor's order of administering continuous O2 to Resident 11. LVN 1 stated Resident 11 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could be at risk for further desaturation (drop in blood oxygen levels below normal) and respiratory distress and potential transfer to the hospital without the oxygen. During an interview on 5/7/2026 at 10:33 AM with CNA 2 and CNA 3, CNA 2 stated she removed the NC from Resident 11 prior to providing bed bath (cannot remember exact time) and placed the NC and tubing in the plastic bag. CNA 2 and CNA 3 stated they did not know and were not provided education that CNAs cannot touch or remove O2 NC from the residents. During a concurrent interview and record review with the Director of Nursing (DON), the policy and procedure (P&P) titled Oxygen Administration - Respiratory and Pulmonary Conditions, reviewed 1/26/2026, was reviewed. The P&P indicated to verify that there is a physician's order for this procedure. The DON stated the P&P did not specifically indicate who cannot touch the O2 cannulas. The DON stated unlicensed staff cannot remove or put back O2 of residents. The DON stated physician's order was not followed when O2 was taken off Resident 11. The DON stated this placed Resident 11 at risk for desaturation, hypoxemia (a condition where the body's tissues and organs are not receiving enough O2 causing them to function poorly), decline in function, and hospital transfer. During a concurrent interview and record review with the Administrator (ADM), the P&P titled, Oxygen Administration, review date of 1/29/2026, was reviewed. The P&P indicated:All oxygen therapy requires a complete medical order including:Flow rate (L/min)Delivery deviceFrequency/continuous useHumidification, if anyTarget O2 saturation, if ordered Registered Nurse (RN) verifies order accuracy and initiates therapy.CNAs may observe and report changes in breathing, ensure O2 device stays in place, and never adjust O2 flow rates. The ADM stated CNAs are not allowed to remove and reapply O2 device from residents.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide trauma-informed care (an approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of traumas) for one of two sampled resident (Resident 8) reviewed for behavior and diagnosed with post-traumatic stress disorder (PTSD, a disorder in which a person has difficulty recovering after experiencing or witnessing a terrifying event).This deficient practice had the potential for Resident 8 to experience re-traumatization, (unintentionally causing harm through practices, policies, and/or activities that are insensitive to the needs of the residents) that could lead to severe psychosocial (dynamic intersection between psychological aspects [thoughts, emotions, and behaviors] and social factors [cultural, environmental, and interpersonal relationships]) harm and negatively affecting his quality of life.Findings:During a review of Resident 8's admission Record, the admission record indicated Resident 8 was admitted to the facility on [DATE], with the diagnoses including but not limited to PTSD, schizoaffective disorders (a mental illness that causes loss of contact with reality), and anxiety disorders (persistent and excessive worry that interferes with daily activities). During a record review of Resident 8's Minimum Data Set (MDS, a resident assessment and tool), dated 1/29/2026, the MDS indicated the resident's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making was intact. The MDS indicated Resident 8 did not have mood or behavior symptoms. The MDS also indicated Resident 8 had a psychiatric (of or relating to the study of mental illness)/mood disorder of PTSD. During a record review of Resident 8's Social Service assessment dated , 1/22/2026 and 4/28/2026, both assessments did not include the history of trauma and what stressors trigger (anything including sound, sight, smell or thought that is a reminder of a traumatic event) an event for the resident. During a record review of Resident 8's Care Plans dated from 1/21/2026 to 5/6/2026, there were no care plans for Resident 8's PTSD. During an interview on 5/6/2026 at 4:33 PM with Social Service Director (SSD), SSD stated SSD was informed by Resident 8 that the resident had PTSD. SSD stated SSD did not document or have an assessment done for Resident 8's PSTD. During an interview on 5/7/2026 at 9:29 AM with Certified Nursing Assistant 5 (CNA 5), CNA 5 stated Resident 8 was not sure if Resident 8 had PTSD. CNA 5 stated he did not know what PTSD was and therefore was not able to provide the best possible care for Resident 8 with a diagnosis of PTSD. During a concurrent interview and record review on 5/7/2026 at 10:43 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 8's Care Plan dated from 1/21/2026 to 5/6/2026 was reviewed. LVN 2 stated Resident 8 had a diagnosis of PTSD. LVN 2 stated Resident 8's Care Plan should contain the information of Resident 8's history related to PTSD, triggers, and trauma informed care interventions. LVN 2 stated Resident 8 did not have a specific care plan for PTSD. LVN 2 stated it was important to know the underlying causes and the triggers for Resident 8's PTSD to avoid the triggers. During a concurrent interview and record review on 5/7/2026 at 2:47 PM with the Director of Nursing (DON), Resident 8's electronic health records dated from 1/21/2026 to 5/6/2026 was reviewed and the facility's Policy and Procedure (P&P) for Trauma-Informed and Culturally Competent Care dated 1/26/2026 were reviewed. The P&P indicated resident assessment involves an in-depth process of evaluating the presence of symptoms, their relationship to trauma, as well as the identification of triggers; utilize licensed and trained clinicians who have been designated by the facility to conduct trauma assessments, and use assessment tools that are facility-approved and specific to the resident population. The P&P also indicated to develop an individualized care plan that address past trauma in collaboration with the resident and family as appropriate. Resident 8's electronic health records did not indicate assessment, evaluation and care plan regarding the resident's PTSD triggers and there was no care plan. The DON stated she did not know about the history of Resident 8's PTSD such as what triggers it to prevent any outbursts from happening and what interventions works to prevent any triggers for Resident 8's PTSD. The DON (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated there was no documentation for an assessment done for an evaluation to Resident 8's trauma and triggers or a care plan for Resident 8's PSTD as indicated on the P&P. The DON stated it was important to know about Resident 8's PSTD so staff could provide trauma informed care, prevent further episodes, and avoid triggers. During a record review of the facility's P&P titled, Care Plans, Comprehensive Person-Centered, revised 3/2022, the P&P indicated the interdisciplinary team (IDT, group of healthcare professionals from diverse fields who work in a coordinated manner toward a common goal for the resident), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The P&P also indicated, services provided for or arranged by the facility and outlined in the comprehensive care plan are provided by qualified persons, culturally competent, and trauma-informed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services for one (1) of six (6) sampled residents (Resident 42) observed for medication administration by failing to ensure Licensed Vocational Nurse 5 (LVN 5) administered Carvedilol (medication used to treat hypertension [high blood pressure] and congestive heart failure [CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling]) with food on 5/5/2026 to Resident 42 as indicated on the physician's order and facility policy. This deficient practice had the potential for Resident 42 to experience gastrointestinal discomfort, nausea, and the risk for side effects such as dizziness, fainting, and sudden low blood pressure.Findings:During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was admitted to the facility on [DATE], with diagnoses that included type 2 diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), leukemia (a cancer of the body's blood-forming tissues), and essential primary hypertension. During a review of Resident 42's Minimum Data Set (MDS- a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 42 had moderately impaired cognitive (ability to understand and make decisions) skills for daily decision making. The MDS indicated Resident 42 was dependent (helper does all the effort) with toileting, bathing self, personal hygiene and independent (resident completes activity with no assistance) with eating. During a review of Resident 42's Order Summary Report, the Order Summary Report indicated carvedilol oral tablet 3.125 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) give 1 tablet by mouth two times a day related to essential primary hypertension. Give with food. Order started 4/10/2026. During an observation on 5/5/2026 at 4:54 PM in Resident 42's room entry, LVN 5 was observed administering Carvedilol 3.125 mg to Resident 42 without food. During an interview on 5/5/2026 at 4:57 PM with LVN 5, LVN 5 stated she did not administer Carvedilol 3.125 mg to Resident 42 with food. LVN 5 stated she should have administered it with food as indicated on the physician's order. LVN 5 also stated she did not see the resident eating or ask the resident when she last ate before giving her the medication. LVN 5 stated she should have given Resident 42 the medication once she was eating dinner. LVN 5 stated it was important to give the medication as prescribed with food to prevent the medication from [negatively] affecting Resident 42's stomach. During an interview on 5/7/2026 at 11:48 AM with the Director of Nursing (DON), the DON stated medications are to be given as prescribed and Resident 42's carvedilol should have been given with crackers, applesauce or her dinner tray. The DON stated staff are to ensure residents are eating something when the medication is administered, if ordered to give with food. The DON further stated it was important to give as prescribed with food to prevent side effects or harm to the residents. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated 1/26/2026, the P&P indicated medications are administered in a safe and timely manner, and as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure Medication Cart 1 remained locked while unattended during medication administration on 5/5/2026 as indicated in the facility's policy. This deficient practice had the potential for unauthorized access to medications by residents, staff and visitors which could lead to medication overdose (taking a toxic or poisonous amount of a drug or medicine), unauthorized use, adverse reactions (any unexpected or dangerous reactions to a drug), or harmful drug interactions (a reaction between two or more drugs or between a drug, and a food, beverage, or supplement).Findings: During an observation on 5/5/2026 at 3:48 PM in the facility hallway, Medication Cart 1 was observed unlocked and unattended while Licensed Vocational Nurse 5 (LVN 5) was inside Resident's Room A. During an observation on 5/5/2026 at 4:22 PM, in the facility hallway, Medication Cart 1 was observed unlocked and unattended while LVN 5 was inside Resident's Room B. During an interview on 5/5/2026 at 4:57 PM with LVN 5, LVN 5 stated that per facility protocol, the medication cart should be locked every time staff leave it and go anywhere, for privacy and safety, because anyone could access the medications from an unlocked cart and take them. During an interview on 5/7/2026 at 11:48 AM with the Director of Nursing (DON), the DON stated that medication carts must be locked as soon as the nurse's back is turned to the cart to ensure resident safety and to prevent residents from accessing medications. During a review of the facility's Policy and Procedure (P&P) titled, Medication Labeling and Storage, dated 1/29/2026, the P&P indicated the facility stores all medications and biologicals in locked compartments. The policy also indicated compartments (including carts) containing medications and biologicals (medication that are made using biological substances) are locked when not in use, and carts used to transport such items are not left unattended if open. During a review of the facility's P&P titled, Administering Medications, dated 1/26/2026, the P&P indicated during administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555894	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothill Heights Care Center	1515 North Fair Oaks Ave Pasadena, CA 91103

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the nurse staffing information (real-time data regarding the number and types of nursing staff currently on duty) was updated and posted daily on 5/2/2026 and 5/3/2026, according to the facility's policy. As a result, the current resident census, total number of staff and the actual hours worked by the staff were not readily accessible to residents and visitors.Findings:During an observation on 5/4/2026 at 7:49 AM, at the Business Office's door, the staffing information posted indicated the date of 5/1/2026. During an interview on 5/7/2026 at 2:01 PM with the Director of Staff Development (DSD), the DSD stated she is the staff responsible for posting the daily nurse staffing information and it is posted on the door of the Business Office. The DSD further stated she does not work on Saturdays or Sundays, so no daily posting of the nurse staffing information was done on 5/2/2026 and 5/3/2026. The DSD stated she updates and posts the staffing once returning to work on Mondays. The DSD stated daily nurse staffing is posted to ensure staff are aware of the nursing hours and that there is enough staffing for the day. During a review of the facility's policy titled, Posting Direct Care Daily Staffing (nurse staffing informational) Numbers, dated 1/29/2026, the policy indicated the facility will post on a daily basis for each shift nurse staffing data, including the number of personnel responsible for providing direct care to residents. The policy also indicated within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing information form and posts the staffing information in the designated location(s).