STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555932	A. Building B. Wing	08/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Heights Health Center	161 S. Reeder Ave Covina, CA 91724

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. (continued on next page)

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

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain and maintain a copy of the Advance Directive (AD - legal document indicating resident preference on end-of-life treatment decisions) in the same section of the resident's medical record readily retrievable by any facility staff for two of two sampled residents (Resident 3 and Resident 13) who had executed an AD.This failure had the potential for Resident 3 and Resident 13 to receive inappropriate or medically unnecessary care and/or treatment or services regarding life-sustaining treatment. Findings:During a review of Resident 3's Profile Face Sheet (PFS), the PFS indicated, Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (hemiplegia - total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarct (infarction), [cerebral infarction or stroke - a condition where brain tissue dies due to a lack of blood supply) affecting right dominant side, cognitive (think, learn, remember, understand and process information) communication deficit, and vascular dementia (a type of dementia [a progressive state of decline in mental abilities] caused by reduced or blocked blood flow to the brain), unspecified severity, without behavioral disturbance/psych (psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality)/mood/anx (anxiety - intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 3's History and Physical Examination (H&P), dated 3/28/2025, the H&P indicated, Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2025, the MDS indicated, Resident 3 had no speech (absence of spoken words) and Resident 3's ability to express ideas and wants were rarely/never understood. The MDS indicated, Resident 3's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 3 was dependent (helper does all of the effort) in self-care and was receiving hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility).During a review of Resident 13's PFS, the PFS indicated, Resident 13 was admitted to the facility on [DATE] with multiple diagnoses including unspecified atrial flutter (a type of abnormal heart rhythm that's too fast), essential (primary) hypertension (HTN - high blood pressure), and unspecified sequelae (an aftereffect of a disease, condition, or injury) of cerebral infarction. Resident 13's H&P, dated 3/28/2025, the H&P indicated, Resident 13 had the capacity to understand and make decisions.During a review of Resident 13's MDS, dated 3/29/2025, the MDS indicated, Resident 13 had clear speech (distinct intelligible words) and Resident 13's ability to express ideas and wants were understood. The MDS indicated, Resident 13's BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident), was intact. The MDS indicated, Resident 13 required partial/moderate assistance (helper does less than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for self-care.During a concurrent interview and record review on 8/5/2025 at 9:03 AM with the Infection Prevention Nurse (IPN), Resident 3 and Resident 13's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end of life) filed in the chart (medical record) were reviewed. The POLST indicated, the POLST complemented an AD and was not intended to replace an AD. Resident 3's POLST dated 3/26/2025 indicated, an AD dated 8/19/2013 was available and reviewed. Resident 13's POLST dated 4/1/2025 indicated, an AD dated 8/19/2013 was available and reviewed. The IPN stated, the AD was kept in the resident's (in general) chart. The IPN stated, the IPN could not find a copy of Resident 3 and Resident 13's AD in the chart. The IPN stated, it was important to have a copy of the AD on file so staff would know who to reach out to with regards to resident care and decision and to know what the resident's wishes were especially in the event if life saving measures were needed or not. The IPN stated, it was the Social Services (SSD) who was responsible for obtaining a copy of the AD. During a concurrent interview and record review on 8/5/2025 at 9:39 AM with the SSD, Resident 3 and Resident 13's charts were reviewed. The SSD stated the SSD would conduct an assessment and provide information regarding the AD to the resident or responsible party upon admission and request a copy of the AD if the resident had an AD. The SSD stated, the AD was kept under the AD tab in the chart. The SSD stated, the SSD could not find a copy of Resident 3 and Resident 13's AD in the chart. The SSD stated, it was important to have a copy of the AD on file so staff

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete and transmit the initial minimum data set (MDS, a standardized assessment and care-screening tool) assessment in a timely manner for one of one sampled residents (Resident 29) as indicated in the Centers for Medicare & Medicaid Services (CMS is a federal agency that manages health care programs in the United States) Resident Assessment Instrument (RAI, a tool used by nursing homes to assess the needs, strengths, and preferences of residents) manualThis deficient practice resulted in a late completion and transmission of MDS assessment to Centers of Medicare and Medicaid (CMS) Quality Improvement and Evaluation System (QIES) Assessment Submission and Processing (ASAP) system. This had the potential to affect the facility's quality monitoring data. Findings: During a review of Resident 29's profile face sheet indicated Resident 29 was admitted to the facility on [DATE].During a review of Resident 29's admission Diagnosis (AD), dated 4/24/2025, the AD indicated diagnoses that included venous thromboembolism (blood clots form in the vein [vessel]), anemia (not enough red blood cells in the body to carry oxygen [colorless, odorless gas]), and insomnia (difficulty sleeping). During a review of Resident 29's Physicians Orders (PO), the physician's order indicated the resident was discharged out of the facility on 5/15/5025.During a record review of Resident 29's MDS initial comprehensive assessment, dated 3/18/2025, the MDS indicated the assessment completion date was completed on 3/28/25. During an interview and concurrent record review of the MDS 3.0 NH Final Validation Report (NHFVR) with the MDS coordinator (MDSC) on 8/6/2025 at 2:46 pm, the MDSC indicated that Resident 29's entry (NT) was submitted late, the submission date is more than 14 days after the entry tracking record. The MDSC stated Resident 4's initial comprehensive assessment was submitted on 5/9/2025 but should have been submitted by 3/29/2025. The MDSC stated it was important to submit the MDS in a timely manner (within 14 days) so CMS will know that Resident 4 was assessed and properly taken care of.During an interview with the Director of Nursing (DON) on 8/6/2025 at 5:25 pm, the DON stated the MDS comprehensive assessment is done 14 days post admission to ensure proper communication is done between CMS and the facility regarding the kind of care that will be provided to Resident 29. A review of the MDS RAI Version 3.0 Manual, Chapter 5: Submission and Correction of the MDS Assessments, dated 10/2024, indicated under Assessment Transmission, . MDS assessments must be submitted within 14 days of MDS Completion Date.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to screen one of one of sampled resident (Resident 4) for Preadmission Screening and Resident Review (PASARR). Resident 98 has a mental illnesses including schizophrenia (a mental disorder effecting how a person thinks and feels), bipolar (a brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks) and depression (mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life, often with other symptoms such as disturbed sleep, feelings of guilt or inadequacy, and suicidal thoughts) and was receiving psychotropic medication. This deficient practice had the potential to result in Resident 4 to not receive special services for treatment of mental illnesses.Findings: A review of Resident 4's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included schizophrenia, bipolar disorder and major depression. A review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 3/20/2025 indicated the resident was cognitively impaired and required maximal assistance (helper does more than half the effort) for transferring, dressing, oral and toileting hygiene. During an interview and concurrent record review with the Minimum Date Set Coordinator (MDS), on 8/5/2025 at 2:27 pm, the MDSN stated the last PASSAR screening on record for Resident 4 was on 12/31/2024. The MDSN stated there were no records for any type of PASSAR screening other than the one dated 12/31/2024. During an interview and concurrent record review of Resident 4's paper and electronic chart with the Director of Nursing (DON) on 8/5/2025 at 2:33 pm, the DON stated the facility did not submit a PASSAR screening for Resident 4 before and after the resident's admission. DON stated PASSR screenings were important to determine the kind of service the resident needed and to ensure the appropriate care rendered meets Resident 4's individual needs. A review of the facility's policy and procedure titled, admission Criteria for Long Term Care, dated 12/23/2021 indicated all new admission and readmission are screened for mental disorders (MD), intellectual disabilities (ID), or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The facility conducts a Level I PASARR screen for all potential admission, regardless of payer source, to determine if the individual meets the criteria for MD, ID or RD.

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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 ensure professional standards of nursing practice were followed during a blood draw by venipuncture (a medical procedure that involves inserting a needle into a vein to draw blood) for one of one sampled resident (Resident 1) who had a Peripheral (situated on the edge) Central Catheter (PICC - a type of central venous catheter [CVC, thin flexible tube inserted into a large vein [vessel] typically in the neck, chest, or groin, and threaded into a central vein near the heart to access the bloodstream for administering medications) line for long-term central venous access. This deficient practice had the potential to result in catheter malfunction, an infection, or physical decline to Resident 1.Findings:During a review of Resident 1's Profile Face Sheet (PFS, admission record), the PFS indicated Resident 1 was originally admitted to the facility 4/14/2024 and readmitted [DATE] with diagnoses that included: overactive bladder (hollow muscular organ that acts as a reservoir for urine) and gastro-esophageal reflux disease (GERD; digestive disorder that occurs when acidic stomach juices, or food and fluids back up from the stomach into the esophagus [muscular tube through which food passes from the throat to the stomach]).During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 7/8/2025, the MDS indicated Resident 1's cognition (ability to understand and process information) was intact. During a concurrent observation and interview on 8/4/2025 at 9:25 AM, Resident 1 had a PICC line on Resident 1's left upper arm and had an antibiotic (medication used to treat infections [harmful microorganisms such as bacteria [living organism that can cause an infection] enter the body and multiply]) running through the line. There was a folded gauze dressing 1 inch below the anterior (situated in front) aspect of the left elbow. Resident 1 stated it was from a blood draw performed early that morning. During an interview on 8/4/2025 at 3:20 PM with Director of Nursing (DON) 1, DON 1 stated for residents (in general) who had PICC lines, if the resident did not want blood drawn on the other [right] arm, the lab needed to communicate with the [nursing] staff because the staff could draw blood directly from the PICC line. DON 1 stated collecting blood by needle stick (needle is used to collect blood from a vein) from the same arm as the PICC line could potentially lead to an infection and catheter damage.During an interview on 8/6/2025 at 4:20 PM with the Infection Prevention Nurse (IPN), the IPN stated the IPN could not find any nursing resources written or online, indicating it was an acceptable nursing practice to draw blood by needle stick from the same arm where the PICC line was located. The IPN stated the facility did not know when laboratory staff drew blood from Resident 1's left arm because laboratory staff did not communicate this action to the facility staff. The IPN stated the facility did not provide laboratory staff with a reminder or cautioned laboratory staff to avoid venipuncture on Resident 1's left arm. During a review of the facility's Policy and Procedure (P&P) titled CVC Dressing Change, dated July 2023, the P&P indicated (in bold and capital letters), NEVER USE SCISSORS OR ANY SHARP OBJECT AROUND THE CATHETER. During a review of the National Institute of Medicine (NIH), undated, guideline for managing central lines, the guideline indicated to avoid venipuncture, peripheral intravenous (a soft flexible tube placed inside a vein, usually in the hand or arm and used to give a person medicine or fluids) catheter insertion, and taking blood pressure on the same arm where the PICC line is located. The guideline indicated to place reminder signs for the healthcare team members. https://www.ncbi.nlm.nih.gov/books/NBK594495/

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 3), who was unable to carry out activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) received the necessary services to maintain personal and oral hygiene (refers to the maintenance of a healthy mouth, which includes not only teeth, but the lips, gums, and supporting tissues.) This failure had the potential for Resident 3 to develop mildly uncomfortable to severely painful discomfort, pain and/or bleeding from cracked lips. Findings:During a review of Resident 3's Profile Face Sheet(PFS), the PFS indicated, Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (hemiplegia - total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction, [cerebral infarction or stroke - a condition where brain tissue dies due to a lack of blood supply) affecting the right dominant side, cognitive (think, learn, remember, understand and process information) communication deficit, and vascular dementia (a type of dementia [a progressive state of decline in mental abilities] caused by reduced or blocked blood flow to the brain), unspecified severity, without behavioral disturbance/psych (psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality)/mood/anx. (anxiety - intense, excessive, and persistent worry and fear about everyday situations).During a review of Resident 3's History and Physical Examination (H&P), dated 3/28/2025, the H&P indicated, Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2025, the MDS indicated, Resident 3 had no speech (absence of spoken words) and Resident 3's ability to express ideas and wants were rarely/never understood. The MDS indicated, Resident 3's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 3 was dependent (helper does all of the effort) for self-care and was receiving hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility).During a review of Resident 3's Care Plan (CP - provides direction on the type of nursing care an individual needs that include goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan), titled, (Resident 3) is at risk for impaired functional status with selfcare and mobility., date started 7/18/2025, the CP indicated, one of the interventions included to assist with ADLs as necessary.During a concurrent observation and interview on 8/4/2025 at 9:10 AM with Certified Nursing Assistant (CNA) 1, Resident 3 was in bed, awake, nonverbal and did not follow commands. Resident 3 had an enteral feeding (nutrition taken through the mouth or through a tube that goes directly to the stomach or small intestine) via a G-tube (gastrostomy tube - a tube inserted through the belly that brings nutrition directly to the stomach). Resident 3's lips were dry, chapped, rough looking with small crack areas and pieces of flaking. CNA 1 stated, Resident 3's lips were dry. CNA 1 stated, staff did mouth care after residents (in general) ate. CNA 1 stated, Resident 3 did not eat. CNA 1 stated mouth care was important to prevent chapped lips that could cause bleeding.During an interview on 8/6/2025 at 10:35 AM with the Infection Prevention Nurse (IPN), the IPN stated, Resident 3 was on hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) care and the hospice staff provided personal care to Resident 3 but the facility staff also provided the care including oral care. The IPN stated, Resident 3's lips should not be dry and chapped that could lead to discomfort and pain. The IPN stated, oral care was important for Resident 3's comfort, wellbeing and dignity. During an interview on 8/6/2025 at 12:03 PM with the Director of Nursing (DON), the DON stated, the facility provided care whether a resident (in general) was on hospice care or not. The DON stated it's still the same care, including oral care to prevent cracks and it's a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADL), Supporting, revised 3/2018, the P&P indicated residents who were unable to carry out ADLs independently would receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. During a review of the facility's P&P titled, SNF - Chapter 12 - Resident Rights 012 Resident Rights, date reviewed/revised 1/10/2022, the P&P indicated employees should treat all residents with kindness, respect, and dignity. The P&P indicated, these rights included the resident's right to a dignified existence.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate care and services were provided for three of three sampled residents (Resident 8, Resident 3, and Resident 32) by failing to ensure:a. Resident 8, who was on anticoagulant (medication that thins the blood) therapy, was monitored for bleeding in the months of May, June, and July 2025 and Resident 32 who was on anticoagulant therapy was monitored for bleeding in July and August 2025.b. Resident 3's hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) physician orders were followed and/or clarified.c. Resident 32's discharge teaching and instructions included an evaluation of Resident 32 and Resident 32's knowledge about diabetes management (a variety of strategies to control blood glucose [sugar] levels and minimize the risk of complications associated with Diabetes [a disease that results in elevated levels of glucose in the blood]) and provide needed education including but not limited to blood sugar checks, insulin management, and watching for signs and symptoms of hypoglycemia and hyperglycemia.These failures had the potential to result in serious health complications and hospitalization for Resident 8 and Resident 32 and the potential for Resident 3 to inappropriate hospice care.Cross Reference F745 Findings: a. During a review of Resident 8’s “Profile Face Sheet (PFS),” the “PFS” indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including pneumonia (an infection/inflammation in the lungs), unspecified organism, heart failure, unspecified, and chronic atrial fibrillation (AFib - rapid, irregular heartbeat for extended periods), unspecified. During a review of Resident 8’s “History and Physical Examination (H&P),” dated 5/5/2025, the “H&P” indicated, Resident 8 could make needs know but could not make medical decisions. During a review of Resident 8’s “Minimum Data Set (MDS – a resident assessment tool),” dated 5/7/2025, the “MDS” indicated Resident 8’s “BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident),” was moderately impaired. The “MDS” indicated Resident 8 was taking high-risk drugs including an anticoagulant (e.g. warfarin, heparin, or low-molecular weight heparin). During a review of Resident 8’s “Physician’s Orders (PO),” as of 8/6/2025, the “PO” indicated, a physician’s order, dated 5/27/2025 for Xarelto (an anticoagulant) 20 mg (milligrams – metric unit of measurement) tablet [Rivaroxaban] – one tab by mouth once a day with meals for chronic AFib. During a review of Resident 8’s “Care Plan (CP),” titled, “Resident 8 is at risk for bleeding/development of skin discolorations related to usage of: Xarelto” dated start 7/1/2025, the CP indicated one of the interventions was to monitor for signs and symptoms of bleeding. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/5/2025 at 1:39 PM with the Infection Prevention Nurse (IPN), Resident 8’s Treatment Record (TAR) and Resident 8’s Medication Record (MAR), dated for the months of May, June, and July 2025 were reviewed. The “TAR” did not indicate a monitoring for bleeding. The MAR indicated monitoring for bleeding, start date of 5/9/2025, but the “MAR” was coded with an “X” for all the dates. The IPN stated when a resident (in general) was on an anticoagulant, staff were to monitor for bleeding and care plan. The IPN stated it was important to monitor because of the risk of bleeding and for the safety of the resident. The IPN stated the monitoring was either documented in the TAR or MAR. The IPN stated the IPN would have to check with Medical Records (MR) what the “X” meant on the “MAR.” During a concurrent interview and record review on 8/5/2025 at 2:02 PM with the MR, Resident 8’s “MAR dated for the months of May, June, and July 2025 were reviewed. The MR stated, the “X” coded on the MAR meant there was no schedule for staff to document. During an interview on 8/5/2025 at 2:05 PM with the IPN, the IPN stated the MAR should not have been coded “X” because the order to monitor for bleeding could get missed or not done. During a concurrent interview and record review on 8/6/2025 at 12:03 PM with the Director of Nursing (DON), Resident 8’s MAR dated for the months of May, June, and July 2025 were reviewed. The DON stated monitoring for bleeding should be documented in the MAR. The DON stated the coding on Resident 8’s MAR was incorrect and the staff should have questioned the code “X. The DON stated it was important to monitor the resident for bleeding when the resident is on an anticoagulant, because the anticoagulant could cause bleeding, anemia (a condition where the body does not have enough healthy red blood cells) and other complications and for the resident’s safety. During a review of the facility’s revised policy and procedures (P&P) dated 11/2018, titled, Anticoagulation – Clinical Protocol, the P&P indicated residents are assessed for evidence of effects related to the subtherapeutic or greater than therapeutic drug level related to that particular drug (for example, a resident with an above therapeutic level of an anticoagulation medication should be assessed for bleeding). b. During a review of Resident 3’s “PFS,” the “PFS” indicated, Resident 3 was admitted to the facility on [DATE] with multiple diagnoses including hemiplegia (hemiplegia – total paralysis of the arm, leg, and trunk on the same side of the body) following cerebral infarction, [cerebral infarction or stroke - a condition where brain tissue dies due to a lack of blood supply) affecting right dominant side, cognitive (think, learn, remember, understand and process information) communication deficit, and vascular dementia (a type of dementia [a progressive state of decline in mental abilities] caused by reduced or blocked blood flow to the brain), unspecified severity, without behavioral disturbance/psych (psychosis - a severe mental condition in which thought, and emotions are so affected that contact is lost with reality)/mood/anx. (anxiety - intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 3’s “H&P,” dated 3/28/2025, the “H&P” indicated Resident 3 did not have the capacity to understand and make decisions. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3’s MDS, dated [DATE], the MDS indicated Resident 3 had no speech (absence of spoken words) and Resident 3’s ability to express ideas and wants were rarely/never understood. The MDS indicated Resident 3’s cognitive skills for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 3 was dependent (helper does all of the effort) self-care and was receiving hospice care (compassionate care for people who are near the end of life provided at the person’s home or within a health care facility). During a concurrent interview and record review, on 8/6/2025 at 12:03 PM with the DON, Resident 3’s medical records were reviewed. Resident 3 had different physicians order for hospice and for the facility. The hospice physicians orders” dated as of 4/22/2025 included an order dated 4/11/2025 for IDT (Interdisciplinary Team - a group of health care professionals with various areas of expertise who work together toward the goals for the residents) every 14 days to review Resident 3’s status and as needed and order for Lorazepam (medicine used to treat anxiety disorders) 2 mg oral every 4 hours as needed. The DON stated the facility did not conduct an IDT for hospice residents. The DON stated the DON had not “seen this kind of order for hospice.” The DON stated the hospice had standard orders, “hospice kit” when they come to the facility, but the staff followed the facility “PO. ” The DON stated the facility did not follow hospice orders. The DON stated, the facility should have called the hospice to verify the hospice physician order so the staff would be able to provide the accurate plan of care for Resident 3. The DON stated the different physician order for hospice and for the facility could result in confusion to the staff which physician order to follow and would complicate and affect the care provided to Resident 3. During a review of the facility’s policy and procedure (P&P) titled, “Hospice Program,” revised date 7/2017, the P&P indicated, in general, it was the “responsibility of the facility” to meet the resident’s personal care and nursing needs in coordination with the hospice representative and ensured that the level of care provided was appropriate. c. During a review of Resident 32’s PFS, the PFS indicated the facility admitted Resident 32 on 6/25/2025. During a review of Resident 32’s MDS, dated [DATE], the MDS indicated Resident 32’s cognition (ability to understand and process information) was moderately impaired. The MDS indicated Resident 32 required moderate assistance (helper does less than half the effort. The helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with personal hygiene and toileting hygiene. The MDS indicated Resident 32 had diagnoses that included Diabetes Mellitus (DM, a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine), and end stage renal disease (ESRD - a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life). During a review of Resident 32’s Physician Orders (PO) as of 7/28/2025, the PO indicated an order for Eliquis (medication used to prevent and treat blood clots) 2.5 milligrams (mg) two times a day for atrial fibrillation (AFIB - causes your heart to beat irregularly and sometimes much faster than normal). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32’s CP titled “Risk for Bleeding/Development of Skin Discolorations,” dated November 2018, related to the use of Eliquis. The CP’s interventions indicated Resident 32 would be monitored for signs and symptoms of bleeding and to report/monitor/document for any presence or formation of skin discolorations. During a concurrent review of Resident 32’s Medication Administration Record (MAR), dated July and August 2025, and interview on 8/6/2025 at 4:15 PM with the Minimum Data Set Nurse (MDSN), the MARs indicated no monitoring for signs and symptoms of bleeding. The MDSN stated there was no monitoring for signs and symptoms of bleeding. The MDSN stated the MAR was the only location to document monitoring for signs and symptoms of bleeding. During an interview on 8/5/2025 at 8:33 AM with the Family Member (FM, Resident 32’s son), the FM stated the plan was to discharge Resident 32 home today, 8/5/2025. During an interview on 8/5/2025 at 11:17 AM with the Social Services Director (SSD), the SSD stated Resident 32 would be discharged [home] on 8/5/2025. The SSD stated the SSD sent a request via fax for a Home Health (HH - medical and supportive services provided in a patient's home to help them manage their health conditions, recover from illness or injury) Registered Nurse (HH RN) to visit Resident 32 [at home]. The SSD stated the SSD would follow up [on the fax requesting services] by calling the HH Agency [prior to Resident 32’s discharge home]. During an interview on 8/5/2025 at 3:05 PM, the SSD stated Resident 32 had left the facility (discharged) with the FM. The SSD stated the SSD did not call to confirm services with the HH Agency to inquire when the HH RN would visit Resident 32 [at home]. During a concurrent interview and record review on 8/5/2025 at 3:24 PM, with Registered Nurse 1 (RN 1). Resident 32’s “Post Discharge Plan of Care,” dated 8/5/2025, the plan of care’s Special Training/Instructions indicated, accuchecks (monitoring of blood glucose levels). The plan of care indicated Resident 32 was discharged with the following medications: lantus (insulin glargine - a long acting insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] covers 24 hours or longer) and insulin lispro (a fast-acting insulin that starts to work about 15 minutes after the injection, peaks in about 1 hour, and keeps working for 2 to 4 hours). RN 1 stated Resident 32 was discharged [DATE] and the FM picked up Resident 32. RN 1 stated RN 1 did not know if Resident 32 or the FM knew how to check blood sugars or to administer insulin. RN 1 stated RN 1 would call Resident 32 and the FM to find out. During a follow-up interview on 8/5/2025 at 3:50 PM, RN 1 stated RN 1 was able to call the FM who stated the FM knew how to do accuchecks. RN 1 stated RN 1 was not sure if Resident 32 or the FM knew how to administer insulin. RN 1 stated RN 1 would follow up with the HH Agency to visit Resident 32 on 8/5/2025. During an interview on 8/5/2025 at 4:10 PM with the SSD, the SSD stated SSD was able to get hold of the HH Agency, the HH Agency informed the SSD the HH RN would visit Resident 32 on 8/5/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/5/2025 at 4:15PM with Director of Nursing (DON) 1, DON 1 stated Resident 32 had DM. DON 1 stated Resident 1 required continuity of care at home. DON 1 stated if Resident 32’s blood sugar was not properly managed at home [by an HH RN], Resident 32 could experience low or high blood sugar. DON 1 stated the facility needed to ensure the HH RN visited Resident 32 to ensure continuity of care at home. DON 1 stated coordination of Resident 32’s discharge needs were required. The DON stated [it was important to] evaluate Resident 32’s and the FM’s knowledge pertaining to diabetes management and ensure they understood the teaching and instructions prior to discharge. During a review of the facility’s P&P titled “Discharging the Resident” dated December 2016, the P&P indicated if the resident is being discharged home, ensure that resident and/or responsible party receive teaching and discharge instructions.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure a follow-up for needed services from a Home Health (HH - medical and supportive services provided in a patient's home to help them manage their health conditions, recover from illness or injury) Agency was completed and the service was confirmed prior to discharge home for one of one sampled resident (Resident 32) who required continuity of care at home by HH services for Diabetes management (a variety of strategies to control blood glucose [sugar] levels and minimize the risk of complications associated with Diabetes [a disease that results in elevated levels of glucose in the blood]). This deficient practice had the potential to result in Resident 32 experiencing complications due to uncontrolled Diabetes while at home and could lead to diabetic emergencies such as hypoglycemia (condition where the level of glucose in the blood is too low), hyperglycemia condition where the level of glucose [sugar] in the blood is too high), and a physical decline for Resident 32.Findings:During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2025, the MDS indicated Resident 32's cognition (ability to understand and process information) was moderately impaired. The MDS indicated Resident 32 required moderate assistance (helper does less than half the effort. The helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with personal hygiene and toileting hygiene. The MDS indicated Resident 32 had diagnoses that included Diabetes Mellitus (DM, a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine), end stage renal disease (ESRD - a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis [procedure to remove metabolic waste products or toxic substances from the bloodstream] or a kidney transplant to maintain life). During a review of Resident 32's Profile Face Sheet (PFS), the PFS indicated the facility admitted Resident 32 on 6/25/2025.During an interview on 8/5/2025 at 11:17 AM with the Social Services Director (SSD), the SSD stated Resident 32 would be discharged [home] on 8/5/2025, the SSD stated the SSD sent a request via fax for a Home Health Registered Nurse (HH RN) to visit Resident 32 [at home]. The SSD stated the SSD would follow up [on the fax request for services] by calling the HH Agency [prior to Resident 32's discharge home].During an interview on 8/5/2025 at 3:05 PM, the SSD stated Resident 32 had left the facility (discharged) with Resident 32's son. The SSD stated the SSD did not call to confirm with the HH Agency when the HH RN would visit Resident 32 [at home].During an interview on 8/5/2025 at 4:10 PM with the SSD, the SSD stated SSD was able to get hold of the HH Agency, the HH Agency informed the SSD the HH RN would visit Resident 32 on 8/5/2025.During a review of Resident 32's Interdisciplinary Notes dated 8/5/2025 at 4:14 PM, the IDT notes indicated the SSD followed up with the HH Agency with confirmation the HH RN would conduct the visit on 8/5/2025 between 6 to 7 PM. During an interview on 8/5/2025 at 4:15PM with Director of Nursing (DON) 1, DON 1 stated Resident 32 had DM. DON 1 stated Resident 1 required continuity of care at home. DON 1 stated if Resident 32's blood sugar was not managed appropriately at home [by an HH RN], Resident 32 could experience low or high blood sugar. DON 1 stated the facility needed to ensure the HH RN visited Resident 32 to ensure continuity of care at home. DON 1 stated coordination of Resident 32's discharge needs were required to ensure Resident 32's discharge teaching and instruction on diabetes management was completed and Resident 32's family members understood the teaching and instructions prior to discharge. During a review of the facility's Position Description (PD) for the Director of Social Services, the PD indicated the Director interacts with all departments and functions as a case manager in terms of coordinating all aspects of discharge and follow up to lower levels of care.During a review of the facility's Policy and Procedure (P&P) titled Skilled Nursing Facility Discharge Plan dated 5/18/2018, the P&P indicated the social services staff shall assist in determining the following: Coordination of care between various caregivers and agencies Follow up medical care and appointments Preparation needed by the resident/family for discharge.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in one of one kitchen (Kitchen 1) when five cups of orange colored ice or cream were observed unlabeled and undated in the facility's walk-in freezer. These deficient practices had the potential to result in improper food storage, which could lead to foodborne illnesses. Findings:During an initial tour of Kitchen 1 on 8/4/2025 at 8:42 am, with the Dietary Supervisor (DS), five cups of orange colored ice or cream was observed without a label to indicate what type of food was contained within the cups and a used by or expiration date indicating when the orange substance would expire.During an interview with the DS, on 8/4/25 at 8:43 am, the DS stated the DS was unsure if the five cups contained ice cream or sorbet and did not know when they were prepared. The DS stated the five cups and the tray the cups were placed in did not have a label or a use by date. The DS stated food should always be labeled to ensure the kitchen staff know what kind of food and when the product is edible to avoid infection and for resident food safety. During a review of the facility's policy and procedure titled, Labeling and Dating of Foods, dated 2023, indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated. Items can be dated individually or in bulk stored on a tray with a masking tape if going to be used for meal service. During a review of the facility's policy and procedure titled Leftover Foods, dated 2023, the policy indicated leftover foods will be stored and served in a safe manner. Storage of leftovers will be label and dated.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to ensure the required direct care staffing (employees and contract staff who, through interpersonal contact with residents or resident care management, provided care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being) information based on payroll data for one of two quarters (Quarter 2) was submitted in the Payroll-Based Journal (PBJ - a system implemented by the Centers for Medicare & Medicaid Services [CMS] that requires nursing homes and long-term care facilities to electronically submit auditable and verifiable staffing and payroll data) on the schedule specified by CMS, but no less frequently than quarterly.This failure had the potential to result in CMS's inability to analyze the facility's staffing patterns, monitor/evaluate adequate staffing levels, evaluate the quality of care, and ultimately inform the public through the Nursing Home Compare website and the Five-Star Quality Rating System (a valuable tool used by CMS to help consumers compare nursing homes and make informed decisions about care) which is essential for ensuring quality care to the residents and accountability within the long-term care industry. Findings:During a review of CMS's PBJ Staffing Data Report (PBJR), dated FY (Fiscal Year) Quarter 2 2025 (January 1 - March 31), the PBJR indicated the Failed to Submit Data for the Quarter was triggered (no data submitted for the quarter).During an interview on 8/6/2025 at 3:52 PM with the Administrator (ADM), the ADM stated the facility's corporate controller office in San Francisco was the one submitting the facility's PBJ data. The ADM stated, the previous (unnamed) controller resigned in March 2025. The ADM stated the facility's PBJ data was not submitted because the State had not given the facility the submitter ID (the unique identifier assigned to the individual or entity submitting the PBJ data file to CMS) yet, to the new Controller (CR), There was a transition. The ADM stated, it was important for the facility to submit the PBJ data so that We know the right staffing, the correct staffing to provide care and services to our residents, and to comply with the requirements. During a review of the facility's policy and procedure (P&P) titled, Payroll Based Journal (PBJ) Reporting, revised date 8/6/2025, the P&P indicated it was the policy of the facility to meet the CMS regulations regarding the reporting of data including PBJ data that were used to assess and improve the accuracy of staff data. The P&P indicated, reports were submitted quarterly within the time frame specified.