STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555940	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grossmont Gardens Healthcare Center	5480 Marengo Ave LA Mesa, CA 91942

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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 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. Based on interview and record review, the facility failed to ensure written information regarding an advanced directive (a legal document indicating resident preference on end-of-life treatment decisions) was provided to 10 of 12 sampled residents (14, 8, 12, 19, 15, 7, 20, 5, 6 and 2). This failure resulted in Residents 14, 8, 12, 19, 15, 7, 20, 5, 6 and 2 not having the opportunity to express wishes for care should they lose decision-making capacity.Findings: On 2/10/2026, a review of the clinical records for Residents 14, 8, 12, 19, 15, 7, 20, 5, 6 and 2 was conducted. There was no documentation that the facility provided these residents or their representatives with Advance Directive information. On 2/10/2026 at 12:25 P.M., an interview and record review was conducted with the Social Services Director (SSD). The SSD stated the facility did not provide written information regarding the Advance Directive to residents or their representatives and they should have. On 2/11/2026 at 11:49 A.M., an interview was conducted with the Director of Nursing (DON) and the Administrator (ADM). The DON stated that the facility did not provide written information to residents or their representatives about an Advance Directive. The DON stated there was no documentation in the resident's clinical record that written information regarding the Advance Directive was provided. The ADM stated the facility did not provide written information about an Advance Directive to the resident or resident's representative and it should have been. The ADM stated her expectation was that there should have been documentation in the resident's clinical record that written information of Advance Directive was provided to the resident or the resident's representative. A review of the facility's policy titled Advanced Directives revised September 2022 indicated Determining Existence of Advance Directives .2. The resident or representative is provided with written information concerning the right .to formulate an advance directive if he or she chooses to do so.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or implement resident-specific written care plans for five of 12 residents (11, 16, 20, 14, and 5) when:1. Resident 20's preference for personal belongings was not developed in her care plan.2. Resident 11's written care plan for skin and the use of the low air loss mattress (LAL, a specialized mattress that uses air flow to prevent pressure injuries) was not implemented.3. Resident 16 did not have a care plan developed for his use of the LAL mattress.4. Resident 14's use of clip alarm (a device used to alert staff when a resident was getting up unassisted) was not developed in the fall care plan.5. Resident 5 did not have a care plan developed for continuous oxygen administration. These failures to develop and/or implement residents' written care plans had the potential to cause confusion in the delivery of care. In addition, there was the potential for residents' preferences and goals to be unmet.1. A review of Resident 20's admission Record indicated, the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness affecting one side of the body) following a stroke and aphasia (communication disorder resulting from brain damage). On 2/9/26 at 10:20 A.M., an observation was conducted inside Resident 20's room. Resident 20 was upset when she was asked how she was. Resident 20 was having a hard time expressing and communicating while she stated everything was gone without her knowledge and she did not know where her personal belongings went. Resident 20 was pointing at the dresser in front of her and was looking for something. Resident 20 stated somebody came into her room and moved her belongings. On 2/9/26 at 10:23 A.M., a concurrent observation and interview was conducted with Licensed Nurse (LN 12) inside Resident 20's room. Resident 20's husband was also inside the resident's room. LN 12 stated Resident 20's food was put inside the nightstand drawer by a staff. Resident 20's husband stated the resident's belongings were rearranged and most of Resident 20's personal belongings were missing. Resident 20 was looking for her dentures and other personal hygiene belongings such as deodorant, shampoo, and oral care products. Resident 20's husband stated that the resident's mirror was also put away where she could not find it. Resident 20's husband looked around the resident's room and stated there were a lot of personal belongings that were put away and were not where the resident preferred them to be. On 2/9/26 at 10:40 A.M., an interview was conducted with Resident 20's husband outside of the resident's room. Resident 20's husband stated, as a consequence of her stroke, the resident has lost control of her life and was paralyzed on her right side. Resident 20's husband stated the resident was a former lecturer and became frustrated more often when she was unable to communicate clearly and be understood by others. Resident 20's husband stated it was very important for the resident to have personal belongings insight to aid in communicating her needs to staff. Resident 20's husband stated it was very upsetting that somebody came in and rearranged the resident's personal belongings without her knowledge. Resident 20's husband stated a lot of the resident's personal belongings were moved and put where she could not see them or access them. On 2/9/26 at 10:55 A.M., an interview was conducted with LN 12. LN 12 stated Resident 20 was very particular about her belongings and that staff should have asked permission from Resident 20 before moving and rearranging her belongings. LN 12 stated it was Resident 20's preference to have her personal belongings within view and organized to her liking. LN 12 stated Resident 20's preference should have been care planned and communicated to all staff. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/26 at 2:24 P.M., an interview was conducted with LN 11. LN 11 stated Resident 20 was easily frustrated when she struggled to communicate her needs. LN 11 stated staff should have asked Resident 20 for permission before rearranging her personal belongings. LN 11 stated that it was disrespectful to move or rearrange a resident's personal belongings without their consent. LN 11 stated Resident 20 did not have a care plan for her preferences regarding personal belongings and their use as a means of communication. LN 11 stated Resident 20's preferences for the arrangement of her personal belongings should have been included in her care plan. On 2/12/26 at 1:44 P.M., an interview was conducted with the director of nursing (DON). The administrator and director of staff development were also present. The DON stated it was disrespectful for staff to go into an adult's room and rearrange their belongings without their knowledge. The DON stated respecting Resident 20's preferred location of personal belongings should have been developed into a care plan. The DON stated Resident 20's use of her personal belongings as a means to communicate should have been care planned. 2. A review of Resident 11's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include adult failure to thrive and encounter for palliative care (comfort focused care toward the end of life). A review of Resident 11's physician's order dated 8/4/25, indicated, Pressure Redistribution Mattress- Low Air Loss setting per weight range or per resident's personal preference check function.every shift. A review of Resident 11's Braden Scale (assessment used to determine the risk of pressure injury development) dated 11/13/25, indicated the resident was at high risk for developing a pressure injury. A review of Resident 11's Weights and Vitals Summary dated 2/12/26, indicated the resident weighed 138 lbs. (pounds) on 2/9/26. A review of Resident 11's written care plan for skin dated 6/1/25 indicated, .Pressure Redistribution Mattress- Low Air Loss setting per weight range or per resident's personal preference check function [every shift]. (this intervention was dated 8/8/25). On 2/9/26 at 9:05 A.M., an observation was conducted in Resident 11's room. Resident 11 was sitting up in bed receiving feeding assistance from staff. An interview was attempted, but Resident 11 just stared and did not attempt to speak. Resident 11 was observed to be on a LAL mattress. The LAL mattress was set on the mark between 180 and 210 lbs. On 2/10/26 at 12:16 P.M., an observation was conducted inside Resident 11's room. Resident 11 was lying on her back in bed. The resident's LAL mattress was set on the mark between 180 and 210 lbs. 3. A review of Resident 16's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include stroke. A review of Resident 16's physician's order dated 8/4/25, indicated, Pressure Redistribution Mattress- Low Air Loss setting per weight range or per resident's personal preference check function.every shift. A review of Resident 16's Braden Scale dated 12/23/25, indicated the resident was at risk for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	developing a pressure injury. A review of Resident 16's Weights and Vitals Summary dated 2/12/26, indicated the resident weighed 285 lbs. on 1/2/26. On 2/9/26 at 9:33 A.M., an observation and interview was conducted with Resident 16 while inside the resident's room. Resident 16 was lying in bed on a LAL mattress. The LAL mattress was set on 410 lbs. Resident 16 stated he did not currently have any wounds and that he mainly stayed in bed all day by choice. On 2/10/26 at 12:20 P.M., an observation and interview was conducted with Resident 16. Resident 16 was in bed, and his LAL mattress was set at 410 lbs. Resident 16 asked what it meant when his LAL mattress was set at 410. The resident was informed the setting was by weight. Resident 16 then stated that he was a big guy but I don't weigh that much. I'm almost 300 lbs. Resident 16 stated he did not have a preference for the setting of his LAL mattress and that nurses were responsible for setting his LAL mattress. On 2/10/26 at 12:32 P.M., a joint observation, interview, and record review was conducted with licensed nurse (LN) 21. LN 21 stated the purpose of a LAL mattress was to help prevent the development of pressure injuries and that the setting should correspond to the resident's weight. LN 21 stated, setting the LAL mattress too hard could add pressure, potentially causing a resident to develop a pressure injury. LN 21 reviewed Resident 16's clinical record. LN 21 stated the resident's weight was 285 lbs. LN 21 then observed Resident 16's LAL mattress was set to 410 pbs (pounds) and stated the setting was too high. Following a review of the clinical record again, LN 21 acknowledged Resident 16's physician order dated 8/4/25, indicated to set the LAL mattress according to the resident's weight or preference. LN 21 stated if Resident 16 had a preference, it should have been documented in the clinical record. LN 21 stated without documentation of a resident's preference, the LAL mattress should have been set based on the resident's weight. LN 21 stated Resident 16's LAL mattress should have been set initially to 250 lbs. initially, and if that was too soft, 330 lbs. should have been tried. LN 21 stated there was no documentation to explain why Resident 16's LAL mattress was set at 410 lbs. LN 21 then reviewed Resident 11's clinical record and stated the resident weighed 138 lbs. LN 21 also reviewed Resident 11's physician order dated 8/4/25 and stated resident's LAL mattress should be set by weight or resident preference. LN 21 stated Resident 11 was not cognitively able to express a preference, making it the LN's responsibility to set the resident's mattress by weight. LN 21 then observed Resident 11 in bed and found the LAL mattress was set between 180 and 210 lbs. LN 21 stated, It's set too high. LN 21 stated the setting was at 195 lbs. whereas it should have been set the middle mark between 120 and 150 lbs. LN 21 stated she often forgot to check the residents' LAL mattresses and their settings. On 2/11/26 at 2:24 P.M., a joint interview and record review was conducted with LN 11. LN 11 reviewed Resident 11's written care plan for skin dated 6/1/25. LN 11 stated the care plan was not implemented when the resident's LAL mattress was not set according to the resident's weight. LN 11 then reviewed Resident 16's written care plans and stated the resident's use of the LAL mattress and any preference the resident had regarding its setting was not developed in the care plan. On 2/12/26 at 1:44 P.M., an interview was conducted with the director of nursing (DON). The administrator and director of staff development were also present. The DON stated if Resident 16 had (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a preference to set the LAL mattress at 410 lbs., this should have been figured out a long time ago and documented in the clinical record. The DON stated it was her expectation for residents' LAL mattresses to be set by weight and for the physician's order to be followed. The DON stated Resident 11's care plan for the LAL mattress to be set by weight was not implemented. The DON stated Resident 16's care plan for skin did not have the LAL mattress as an intervention until 2/10/26. The DON stated Resident 16's skin care plan should have included the LAL preference when the resident was first given a LAL mattress. 3. A review of Resident 14's admission Record indicated, the resident was admitted to the facility on [DATE] with diagnoses to include Unspecified Dementia (a condition characterized by memory loss and impaired judgement). On 2/9/26 at 12:53 P.M., an observation was conducted inside the dining room. Resident 14 was observed to be sitting in a wheelchair with a clip alarm attached to her sweater and the wheelchair. A review of Resident 14's physician orders indicated there was no order for the use of the clip alarm. Resident 14's progress notes indicated the resident fell on the following days: 9/2/2025, 10/11/2025, 10/22/2025, and 1/25/2026. On 2/11/26 at 2:24 P.M., a joint interview and record review was conducted with LN 11. LN 11 reviewed Resident 14's physician orders and stated there was no order for the resident's clip alarm, noting there should be an order to utilize that device as an intervention. LN 11 further reviewed Resident 14's written care plan for risk for falls dated 1/12/26 and stated the resident's clip alarm was not developed in the care plan. LN 11 stated she would expect the clip alarm to have been included in Resident 14's care plan as it was a current intervention used to help prevent the resident from falling. On 2/12/26 at 1:44 P.M., an interview was conducted with the director of nursing (DON). The administrator and director of staff development were also present. The DON stated Resident 14 was currently using a clip alarm as an intervention to prevent falls and it should have been care planned. 4. A review of Resident 5's admission record indicated, Resident 5 was admitted on [DATE] with diagnoses which included acute respiratory failure with hypoxia (condition where the lungs cannot adequately oxygenate the blood) and asthma (chronic, non-curable lung disease that causes long-term inflammation, swelling, and narrowing of the airways, making breathing difficult). On 2/09/2026 at 8:33 A.M., an observation and interview was conducted with Resident 5 in Resident 5's room. Resident 5 was lying in bed eating breakfast. Resident 5 had nasal cannula in her nares and was receiving oxygen at 3L/min from the oxygen concentrator located at the right of the resident's bedside. On 2/9/26 at 4:03 P.M., an interview was conducted with Resident 5's family member. Resident 5's family member stated he was unsure why Resident 5 was on oxygen. A review of Physician's Orders dated 11/26/25 indicated Oxygen Therapy Continuous - 3 Liters/Per Minute Via Nasal Cannula. May Titrate Oxygen Up to 5 Liters To Maintain 02 Sats (oxygen saturation - measures the percentage of oxygen-carrying hemoglobin in the blood. Normal levels are usually 95–100%) > 90%. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/11/2026 at 8:03 A.M., an interview and record review was conducted with Licensed Nurse (LN)11. LN11 reviewed the physician's order in Resident 5's clinical record for continuous oxygen therapy at 3L (liter)/min via nasal cannula. LN11 stated there was no care plan for continuous oxygen and there should have been one because the resident was receiving continuous oxygen. On 2/11/2026 at 8:15 A.M., an interview and record review was conducted with LN 12. LN12 reviewed the physician's order in Resident 5's clinical record for continuous oxygen therapy at 3L/min via nasal cannula. LN12 stated there was no care plan for continuous oxygen and stated a continuous oxygen care plan should have been initiated to reflect the current treatment. The care plan was developed on 2/11/26 to include continuous oxygen therapy at 3L/min via nasal cannula. On 2/11/2026 at 11:38 P.M., an interview and record review was conducted with the Director of Nursing (DON). The DON reviewed the physician's order for continuous oxygen therapy at 3L/min via nasal cannula in Resident 5's clinical record. The DON stated a care plan for continuous oxygen should have been developed and it was not. The DON stated it was important to have an accurate care plan to reflect what the resident was currently receiving. A review of the facility's policy titled Care Plans, Comprehensive Person-Centered revised March 2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented.

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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 facility P&P review, the facility failed to ensure food safety and sanitation guidelines were followed when: The cool down process for time, temperature control for safety (TCS) food, food that needs to be kept at specific temperatures to prevent bacteria growth and foodborne illnesses, was not monitored. 2. Gloves were not used appropriately. 3. Facial hair was not covered. These failures posed the risk for foodborne illnesses in a highly susceptible resident population of 21 facility residents who received food prepared in the kitchen. Findings: 1.On 02/10/2026 at 9:50 AM, a concurrent kitchen observation and interview was conducted with Food Services Director (FSD). Ground beef labeled with the day's date and prepared at 8 am was found in the reach in refrigerator. FSD stated that there was no cool down log to monitor the product's temperature during the cooling process. On 02/10/2026 at 9:50 AM, an interview was conducted with [NAME] (CK). CK was asked how food temperatures and cooling are monitored and confirmed he does not monitor cooled foods for time or temperature. CK stated that the kitchen does not maintain a cooling log to track the cooling process for Time/Temperature Control for Safety Food (TCS foods). On 02/10/2026 at 9:50 AM, an interview was conducted with Food Services Manager (FSM). FSM stated that chicken will be cooked and cooled for use in chicken salad; however, no cooling log or other documentation is maintained. On 02/11/2026 at 9:01 AM, an interview was conducted with FSD. FSD stated that a cooling log should be used for safe food handling. FSD confirmed that they did not have a cool down log in place. On 02/11/2026 at 9:01 AM, an interview was conducted with Registered Dietitian Nutritionist (RDN). RDN stated that the expectation for proper cool down is to monitor temperatures and use a cooling log. A review of the facility's policy and procedure titled, Food Preparation and Service, undated, indicated the danger zone for food temperatures is above 41 degrees F and below 135 degrees F. This temperature range promotes the rapid growth of pathogenic microorganisms that cause food borne illness.Potentially hazardous food held in the danger zone for more than 4 hours (if being prepared from ingredients at room temperature) or 6 hours (if cooked and then cooled) may cause food borne illness. According to the USDA Food Code 2022, Section 3-501.14 (A) Cooked time/temperature control for safety food shall be cooled: (1) Within 2 hours from 135 F to 70 F and (2) Within a total of 6 hours from 35 F to 41 F or less. According to the USDA Food Code 2022, Section 3-501.14 Cooling. (B) Time/Temperature Control for Safety Food shall be cooled within 4 (four) hours to 41 degrees Fahrenheit (F) or less if prepared from ingredients at ambient temperature, such as reconstituted foods and canned tuna. 2. On 02/10/2026 between 12:00 and 1:00 PM, an observation of CK was conducted during lunch tray line. The following was observed: - CK wiped his hands on a used cleaning cloth and did not change his gloves or wash his hands before preparing a sandwich, - CK picked up a meal tray ticket off the floor and did not change his gloves or wash his hands before preparing a sandwich, - CK used his gloved hands to open an oven door and then touched a tortilla on a plate, - CK touched the handle of a bin of dishes in the dish room and then picked up a hamburger bun and placed it on a plate. On 02/11/2026 at 9:01 AM, an interview was conducted with FSD. FSD stated that gloves should be worn and changed between tasks for safe food handling. On 02/11/2026 at 11:35 AM, an interview was conducted with RDN. RDN stated that the expectation is that staff are to wear gloves and wash hands in between changing gloves for tasks. A review of the facility's policy and procedure titled, Food Preparation and Service, undated, indicated gloves are worn when handling food directly and changed between tasks. Disposable gloves are single-use items and are discarded after each use. A review of the facility's policy and procedure titled, Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices, undated, indicated gloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves are replaced.c. between handling raw meats and ready-to-eat foods, and d. between handling soiled and clean dishes. 3.On 02/10/2026 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 9:30 AM, an observation was conducted in the kitchen. Server/ Kitchen Aide (SKA) was observed with uncovered facial hair. On 02/10/2026 at 9:58 AM, an interview was conducted with FSD. FSD stated that beard restraints should be worn by those with facial hair. FSD confirmed that SKA should be wearing beard restraint while in the kitchen. On 02/11/2026 at 11:35 AM, an interview was conducted with RDN. RDN stated that beard restraints are available and should be used by staff in the kitchen. Review of the facility's P&P titled Preventing Foodborne Illness: Employee Hygiene and Sanitary practices revised on 11/2022 showed the following:- Hair nets or caps and/or beard restraints are worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils, and linens.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 12 residents (Resident 20) was treated with dignity and respect when Certified Nursing Assistant (CNA) 1 moved the resident's personal belongings without the resident's permission. As a result of this failure, Resident 20 expressed frustration and was upset.A review of Resident 20's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis (paralysis and weakness affecting one side of the body) following a stroke and aphasia (communication disorder resulting from brain damage). On 2/9/26 at 10:20 A.M., an observation was conducted inside Resident 20's room. Resident 20 appeared upset when asked how she was feeling. Resident 20 had difficulty communicating and stated all her belongings were gone without her knowledge. She pointed to her dresser in front of her claiming someone had entered her room and moved her belongings. On 2/9/26 at 10:23 A.M., a concurrent observation and interview were conducted with Licensed Nurse (LN 12) inside Resident 20's room. Resident 20's husband was also present. LN 12 stated Resident 20's food was put inside the nightstand drawer by a staff. Resident 20's husband stated the resident's belongings were rearranged and most of Resident 20's personal items were missing. Resident 20 was looking for her dentures and other personal hygiene items such as deodorant, shampoo, and oral care products. Resident 20's husband stated that the resident's mirror was also put away where she could not find it. Resident 20's husband looked around the resident's room and stated there were a lot of personal belongings that were put away other than where the resident preferred them to be. On 2/9/26 at 10:40 A.M., an interview was conducted with Resident 20's husband outside of the resident's room. Resident 20's husband stated, as a consequence of her stroke, the resident has lost control of her life and was paralyzed on her right side. Resident 20's husband stated the resident was a former lecturer and became frustrated more often when she was unable to communicate clearly and be understood by others. Resident 20's husband stated it was very important for the resident to have personal belongings insight to aid in communicating her needs to staff. Resident 20's husband stated it was very upsetting that somebody came in and rearranged the resident's personal belongings without her knowledge. Resident 20's husband stated a lot of the resident's personal belongings were moved to a place where she could not see or access them. On 2/9/26 at 10:55 A.M., an interview was conducted with LN 12. LN 12 stated Resident 20 was very particular about her belongings and that staff should have asked permission from Resident 20 before moving or rearranging her belongings. On 2/11/26 at 9:21 A.M., an interview was conducted with CNA 1. CNA 1 stated she went inside Resident 20's room on 2/9/26 while the resident was sleeping. CNA 1 stated she did not want to wake the resident, but instead CNA 1 rearranged Resident 20's personal belongings, placing them inside the nightstand drawer to give the room a cleaner appearance. CNA 1 stated she moved Resident 20's dentures from the dresser and put them into the nightstand drawer. CNA 1 stated Resident 20 was upset when she did not see her dentures on top of the dresser and stated, I've never seen [Resident 20] that upset. CNA 1 stated, I should have asked her, before moving the items. On 2/11/26 at 2:24 P.M., an interview was conducted with LN 11. LN 11 stated Resident 20 was easily frustrated when she struggled to communicate her needs. LN 11 stated CNA 1 should have asked Resident 20 for permission before rearranging her personal belongings. LN 11 stated that it was disrespectful to move or rearrange a resident's personal belongings without their consent. On 2/12/26 at 1:44 P.M., an interview was conducted with the director of nursing (DON). The administrator and director of staff development were also present. The DON stated it was disrespectful for staff to go into an adult's room and rearrange their belongings without their knowledge. A review of the facility's policy titled Dignity revised February 2021, indicated, . residents are treated with dignity and respect at all times. staff do not handle or move a (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's personal belongings without resident's permission. A review of the facility's policy titled Personal Property revised August 2022, indicated, .Resident belongings are treated with respect by facility staff, regardless of perceived value.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure that one out of five sampled residents (Resident 14) was free from unnecessary psychotropic (affecting brain activities associated with mental processes and behavior) medication when Resident 14 was prescribed a psychotropic medication as needed for more than 14 days. This failure had the potential for Resident 14 to receive an unnecessary psychotropic medication which can lead to side effects, such as sedation and falls, physical dependence (experiencing unpleasant symptoms if a medication is suddenly stopped), respiratory depression (slowed or shallow breathing) and a decline in psychosocial (how a person feels about themselves and their environment) well-being.Findings:A review of Resident 14's medical records indicated she had active orders for lorazepam (a medication for anxiety, a condition characterized by excessive worrying), including lorazepam 0.5 milligrams (mg, unit of measure) every six hours prn (as needed) end of life anxiety exhibited by agitation with sob (shortness of breath)/fear for 6 months. No Stop Date End of Life Management., dated 12/18/25.During an interview with the Director of Nursing (DON) on 2/12/26 at 2:52 P.M., the DON stated the lorazepam prn order was for 180 days (or 6 months). Because prn psychotropics exceeding a 14-day treatment duration required a specified duration and a rationale for exceeding 14 days, the DON was asked to provide documentation with the prescriber's rationale for using lorazepam prn for 180 days. The DON did not provide documentation.A review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised 2/25, indicated, .PRN Medication.3. PRN orders for psychotropic medications are limited to 14 days. a.if the prescriber.believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure interventions to prevent the development of pressure injuries (tissue injuries that develop from prolonged pressure) were utilized according to physician's orders for two of three residents (11 and 16) when low air loss mattresses (LAL, a specialized mattress that uses air flow to prevent pressure injuries) were not set to the residents' weight.These failures had the potential to cause pressure injuries. Cross reference F656.Findings: 1. A review of Resident 11's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include adult failure to thrive and encounter for palliative care (comfort focused care toward the end of life). A review of Resident 11's physician's order dated 8/4/25, indicated, Pressure Redistribution Mattress- Low Air Loss setting per weight range or per resident's personal preference check function.every shift. A review of Resident 11's Braden Scale (assessment used to determine the risk of pressure injury development) dated 11/13/25, indicated the resident was at high risk for developing a pressure injury. A review of Resident 11's Weights and Vitals Summary dated 2/12/26, indicated the resident weighed 138 lbs. (pounds) on 2/9/26. On 2/9/26 at 9:05 A.M., an observation was conducted while inside Resident 11's room. Resident 11 was sitting up in bed receiving feeding assistance from a staff. An interview was attempted, but Resident 11 just stared and did not attempt to speak. Resident 11 was observed to be on a LAL mattress. The LAL mattress was set on the mark between 180 and 210 lbs. On 2/10/26 at 12:16 P.M., an observation was conducted while inside Resident 11's room. Resident 11 was lying on her back in bed. The resident's LAL mattress was set on the mark between 180 and 210 lbs. 2. A review of Resident 16's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses to include stroke. A review of Resident 16's physician's order dated 8/4/25, indicated, Pressure Redistribution Mattress- Low Air Loss setting per weight range or per resident's personal preference check function.every shift. A review of Resident 16's Braden Scale dated 12/23/25, indicated the resident was at risk for developing a pressure injury. A review of Resident 16's Weights and Vitals Summary dated 2/12/26, indicated the resident weighed 285 lbs. on 1/2/26. On 2/9/26 at 9:33 A.M., an observation and interview was conducted with Resident 16 inside the resident's room. Resident 16 was lying in bed on a LAL mattress. The LAL mattress was set on 410 lbs. Resident 16 stated he did not currently have any wounds and that he mainly stayed in bed all day by choice. On 2/10/26 at 12:20 P.M., an observation and interview was conducted with Resident 16. Resident 16 was in bed, and his LAL mattress was set at 410 lbs. Resident 16 asked what it meant when his LAL mattress was set at 410. The resident was informed the setting was by weight. Resident 16 then stated that he was a big guy but I don't weigh that much. I'm almost 300 lbs. Resident 16 stated he did not have a preference for the setting of his LAL mattress and that nurses were responsible for setting his LAL mattress. On 2/10/26 at 12:32 P.M., a joint observation, interview, and record review was conducted with licensed nurse (LN) 1. LN 1 stated the purpose of a LAL mattress was to help prevent the development of pressure injuries and that the setting should be set according to the resident's weight. LN 1 stated it was not good for the LAL mattress to be set too hard as that could add pressure and cause a resident to develop a pressure injury. LN 1 reviewed Resident 16's clinical record and stated the resident's weight was 285 lbs. LN 1 then observed Resident 16's LAL mattress set to 410 and stated his mattress was set too high. LN 1 left Resident 16's room and reviewed the resident's clinical record again. LN 1 acknowledged Resident 16's physician order dated 8/4/25, indicated to set the LAL mattress according to the resident's weight or preference. LN 1 stated if Resident 16 had a preference, it should have been documented what the preference was in the resident's clinical record. LN 1 stated without the resident's preference documented, the LAL mattress should have been set by the resident's weight. LN 1 stated Resident 16's LAL mattress should have been set initially at 250 lbs. and if that was too soft, 330 lbs. should have been tried. LN (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 stated there was no documentation to explain why Resident 16's LAL mattress was set at 410 lbs. LN 1 then reviewed Resident 11's clinical record and stated the resident weighed 138 lbs. LN 1 also reviewed Resident 11's physician order dated 8/4/25 and stated the resident's LAL mattress should be set by weight or resident preference. LN 1 stated Resident 11 was not cognitively able to express a preference, and it was up to the LN to set the resident's mattress by weight. LN 1 then observed Resident 11 in bed and the LAL mattress was set on the mark between 180 and 210. LN 1 stated, It's set too high. LN 1 stated the mark between 180 and 210 was 195 lbs. LN 1 stated the LAL mattress should have been set on the middle mark between 120 and 150 lbs. LN 1 stated she often forgot to check the residents' LAL mattresses and their settings. On 2/12/26 at 1:44 P.M., an interview was conducted with the director of nursing (DON). The administrator and director of staff development were also present. The DON stated if Resident 16 had a preference to set the LAL mattress at 410 lbs., this should have been figured out a long time ago and documented in the clinical record. The DON stated it was her expectation for residents' LAL mattresses to be set by weight and for the physician's order to be followed. The DON stated it was the responsibility of the charge nurse to monitor the setting of residents' LAL mattresses and not the medication nurse (LN 1). The DON stated there was miscommunication on whose responsibility this was. The DON stated Resident 11 and Resident 16's LAL mattresses were not set by weight and were set too high. The DON stated the charge nurse missed it. A review of the facility's policy titled Prevention of Pressure Injuries revised April 2020, indicated, .Support Surfaces and Pressure Redistribution 1. Select appropriate support surfaces based [sic] the resident's risk factors, in accordance with current clinical practice.

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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. Based on interview and record review, the facility failed to ensure safe and effective pharmaceutical services when:Random controlled medication (medications with a high abuse potential) use audit for three of six sampled residents (Residents 7, 1, 4,) indicated medications were signed out of the controlled drug record (CDR, count sheet used to track controlled medications), but were not documented on the Medication Administration Record (MAR, section of the medical record where all medications given to the resident are recorded to ensure patient safety) to indicate they were administered to the residents.In addition, one of one sampled resident (Resident 8), administrations were documented on the MAR, but not signed out on the CDR.These failures had the potential for diversion (unlawful distribution or use), inadequate narcotic accountability, and the potential to not meet the needs of the residents in the facility.Medications for diabetes (a condition characterized by impaired blood sugar control) were not given in accordance with professional standards of practice and/or prescriber's orders for two of six sampled residents (Residents 21 and 16). This failure had the potential for Resident 21 to not get the full therapeutic benefit of his medications and for Residents 21 and 16 to potentially experience negative health outcomes.In addition, medications for hypertension (HTN, high blood pressure) were administered despite a hold parameter to one of five sampled residents (Resident 5). This failure had the potential for Resident 5 to experience negative health outcomes, such as low blood pressure.Findings:1. During an inspection of Medication Cart 2 conducted with Licensed Nurse (LN) 11 on 2/9/26 at 12:59 P.M., the CDRs for four random residents receiving PRN (as needed) controlled medications were requested for review. One additional CDR was requested from Medication Cart 1 for review on 2/10/26 at 3:32 P.M. from LN 12.A review of Resident 7's medical record indicated an order for morphine sulfate (a controlled medication used to manage pain) 15 milligram (mg, unit of measurement) tablet - give one tablet by mouth every 1 hour as needed, dated 11/18/25.During a concurrent interview and record review with the Director of Nursing (DON) on 2/11/26 at 8:24 A.M., a review of Resident 7's CDR for morphine sulfate 15 mg and MARs for December 2025, January 2026 and February 2026 indicated the nursing staff signed out of the CDR, but did not document the medication administration on four occasions:12/31/25 at 6 P.M.1/13/26 at 3:45 P.M.1/27/26 at 4 P.M.2/4/26 at 4:45 P.M.The DON confirmed there was no documentation on the MAR for the dates and times above. A review of Resident 1's medical record indicated an order for oxycodone (a controlled medication used to manage pain) 5 mg tablet - give one tablet by mouth every 4 hours as needed for severe to worst pain, initiated 5/23/25.During a concurrent interview and record review with the DON on 2/11/26 at 8:24 A.M., a review of Resident 1's CDR for oxycodone 5 mg, August 2025 MAR and September 2025 MAR were reviewed. The CDR indicated the nursing staff signed out one tablet of oxycodone 5 mg, but did not document the medication administration on the following days:8/7/25 at 2:30 A.M.9/5/25 at 11:20 A.M.The DON confirmed the lack of documentation in the medical record for 8/7/25 at 2:30 A.M. and 9/5/25 at 11:20 A.M. A review of Resident 4's medical record indicated an order for morphine sulfate 15 mg tablet - give half of a tablet every 2 hours as needed for severe to worst pain, dated 9/11/25.During a concurrent interview and record review with the DON on 2/11/26 at 8:24 A.M., a review of Resident 4's CDR for morphine sulfate 15 mg, December 2025 MAR and January 2026 MAR were reviewed. Resident 4's CDR indicated nursing staff signed out of the CDR, but did not document the medication administration on two occasions: 12/2/25 at 2:46 P.M. and 1/27/26 at 9:30 P.MThe DON confirmed she could not find any documentation of administration on Resident 4's December 2025 MAR and January 2026 MAR for the above dates and times. A review of Resident 8's medical record indicated orders for hydrocodone-acetaminophen (a controlled medication used to manage pain) 10/325 mg tablet, give one tablet by mouth every 4 hours as needed for moderate to worst pain, dated 5/22/25.During a concurrent interview and record review with the DON on 2/11/26 at 8:24 A.M., a review of Resident (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8's CDR for hydrocodone/acetaminophen 10/325 mg and June 2025 MAR were reviewed. Resident 8's June 2025 MAR indicated nursing staff documented administration on 6/9/25 at 9:07 A.M., but did not sign out of the CDR for that date and time.The DON confirmed the lack of documentation in the CDR for 6/9/25 at 9:07 A.M. The DON stated nursing staff were expected to document controlled medication administration on both the CDR and the MAR. A review of the facility's policy and procedure (P&P) titled, Controlled Substances, revised 11/22, indicated, .Handling Controlled Substances.4.an individual.controlled substance record is made for each resident who will be receiving a controlled substance.This record contains.h. date and time received; i. time of administration.l. signature of nurse administering medication. 2. a) During a concurrent interview and record review of Resident 21's medical record on 2/10/26 at 2:52 P.M. with LN 12, Resident 21 was found to have active orders for two oral medications for diabetes:glipizide 2.5 mg three times a day (at 9 A.M., 2 P.M. and 9 P.M.), dated 1/29/26, andmetformin 500 mg twice a day (at 8 A.M. and 8 P.M.), dated 1/29/26.LN 12 confirmed the scheduled times of administration for both medications.The glipizide bubble pack (a type of packaging for pills that organizes each dose of pills in a clear, plastic bubble) had a green auxiliary label from the pharmacy that indicated, Take This Medicine 1/2 Hour Before A Meal. LN 12 was shown the auxiliary label.The metformin bubble pack prescription label indicated, *TAKE WITH FOOD* LN 12 was shown the prescription label.LN 12 stated mealtimes were 7:30 to 8 A.M. for breakfast, 12:30 P.M. for lunch and dinner was at 5:30 P.M. A drug review of glipizide, provided by the facility, indicated, Give immediate-release tablet about 30 minutes before meals.A drug review of metformin, provided by the facility, indicated, Give drug with meals.A review of Resident 16's medical record indicated an active order for insulin lispro (a medication used to lower blood sugar) 100 units/mL - inject 2 units subcutaneously (into the fat under the skin) before meals and at bedtime. Hold for blood sugar less than 150, dated 8/25/25.Resident 16 received doses, as documented on his December 2025 MAR, January 2026 MAR and February 2026 MAR, despite having a blood sugar less than 150 on the following dates:12/7/25 at 6:30 A.M. blood sugar 1461/2/26 at 11:30 A.M. blood sugar 1002/1/26 at 6:30 A.M. blood sugar 132During a concurrent interview and record review of Resident 16's medical record with the DON on 2/12/26 at 2:52 P.M., DON acknowledged the entries on the MAR on the above dates and times.A drug review of insulins, provided by the facility, indicated side effects such as low blood sugar. c) A review of Resident 5's medical record indicated orders for blood pressure medications, including:carvedilol 12.5 mg two times a day. Hold for SBP less than 110, dated 11/29/25, andlosartan 100 mg one time a day. Hold for SBP (systolic blood pressure, top number in the blood pressure reading) less than 110, dated 11/30/25.Resident 5 received a dose of carvedilol at 8 A.M. and a dose of losartan at 9 A.M. despite having a SBP less than 110 on 12/9/25. Resident 5's blood pressure was 100/60 that morning of 12/9/25.During a concurrent interview and record review of Resident 5's medical record with the DON on 2/12/26 at 2:52 P.M., the DON verified the entries on the MAR on 12/9/25, the blood pressure of 100/60 and the hold parameter of SBP < 110 for carvedilol and losartan.Drug reviews of losartan and carvedilol, provided by the facility, both indicated side effects such as low blood pressure.A review of the facility's P&P titled, Administering Medications, revised 4/19, indicated, .4. Medications are administered in accordance with prescriber orders.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent. The facility's medication error rate was 15% when six medication errors occurred out of 40 opportunities during the medication administration for three of six randomly observed residents (Residents 1, 4, and 16). These failures had the potential for the residents not to get the full therapeutic benefit of their medications or to experience negative health outcomes, such as harm from exposure to medication errors.Findings:During a medication administration observation on 2/9/26 at 8:19 A.M., Licensed Nurse (LN) 21 was observed preparing and administering seven medications for Resident 1. LN 21 stated Resident 1 received her medications crushed and mixed with pudding.LN 21 crushed all of Resident 1's tablets together in one bag and mixed the medications with pudding. The medications included the following tablets:levetiracetam (a medication used to treat seizures) oral tablet 500 milligrams (mg, unit of measurement) - give 1 tablet by mouth two times a day for seizures, dated 11/16/25,ferrous sulfate (iron, a supplement used for anemia, a condition characterized by fatigue and shortness of breath due to a limited ability to carry oxygen in the blood) 325 mg EC (enteric coated, designed to break down in the small intestine instead of the stomach) tablet, one time a day for anemia, dated 5/24/25, andacetaminophen (used for pain) 650 mg ER (extended release, designed to release slowly) tablet four times a day for pain management, dated 1/12/26.During a concurrent interview and record review of Resident 1's medical record with LN 21 on 2/10/26 at 9:21 A.M., LN 21 verified the ferrous sulfate bubble pack (a type of packaging for pills that organizes each dose of pills in a clear, plastic bubble) indicated, EC. LN 21 also verified the acetaminophen bubble pack indicated, ER. LN 21 stated she was unaware not to crush levetiracetam, ferrous sulfate EC and acetaminophen ER.A review of ferrous sulfate enteric-coated tablet package inserts (PI, document from the drug manufacturer on how to safely and effectively use medications), provided by the facility, indicated, Do not crush or chew.A drug review of acetaminophen, provided by the facility, indicated, Give extended-release forms whole; don't crush, dissolve, or allow patient to chew extended-release forms.A drug review of levetiracetam, provided by the facility, indicated, Have patient swallow tablets whole, don't crush or break tablets.During a medication administration observation on 2/9/26 at 8:38 A.M., LN 21 was observed preparing and administering five medications to Resident 4. LN 21 stated Resident 4 also got her medications crushed. LN 21 was observed crushing each of Resident 4's tablets separately and mixing each with pudding.Resident 4's medications included the following:aspirin (used to prevent heart attacks and strokes) 81 mg EC tablet, one time a day, started 5/23/25potassium (an electrolyte that affects heart rhythm) chloride 10 mEq (milliequivalent, unit of measure) ER tablet, one time a day, started 5/23/25.The potassium chloride bubble pack had a green auxiliary label that read, May Be Broken Or Allowed To Disintegrate In Water (Stir Well) Before Swallowing. Rinse Down With Water, But Do Not Chew, All Of The Remaining Particles.During an interview with LN 21 on 2/9/25 at 3:38 P.M., LN 21 confirmed she crushed all of Resident 4's morning medications during the medication administration observation. LN 21 was asked if aspirin EC tablets could be crushed. LN 21 stated no. LN 21 was asked if potassium chloride ER tablets could be crushed. LN 21 read the green auxiliary sticker on the potassium chloride bubble pack.A drug review of aspirin, provided by the facility, indicated, .For patient with swallowing difficulties, crush non-enteric-coated aspirin and dissolve in soft food or liquid. Give liquid immediately after mixing because drug break downs rapidly.Give enteric-coated.whole.A drug review of potassium chloride, provided by the facility, indicated, Don't crush extended-release forms.A review of the facility's P&P titled, Crushing Medications, revised 10/24, indicated, .2. The nursing staff and/or consultant pharmacist shall notify any attending physician who gives an order to crush a drug that the manufacturer states should not be crushed (for example, long-acting or enteric coated medications).During a medication administration observation on 2/9/26 at 9:41 A.M., LN 21 was observed preparing and administrating 12 medications for Resident 16. One of the medications was (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fluticasone/vilanterol (a medication for asthma or chronic obstructive pulmonary disease [COPD], respiratory conditions that affect breathing) 100/25 mcg (micrograms, unit of measure) inhaler. The manufacturer labeling on the medication, as well as the prescription label from the pharmacy, both indicated to discard the medication six weeks after opening. The date opened on the inhaler read, 12/01.During a concurrent interview and record review of Resident 16's medical record with LN 22 on 2/9/26 at 4:35 P.M., LN 22 was asked to set the fluticasone/vilanterol inhaler on top of the Medication Cart. LN 22 saw the date opened and the product labeling indicating the medication was to be discarded six weeks after opening. LN 22 stated the inhaler was no good.A review of the drug fluticasone/vilanterol, provided by the facility, indicated, Discard drug 6 weeks after opening.During an interview with the Director of Nursing (DON) on 2/11/26 at 9:37 A.M., the DON stated the fluticasone/vilanterol inhaler should have been taken out of circulation immediately and reordered.A review of the facility's policy and procedure (P&P) titled, Administering Medications, revised 4/19, indicated, .4. Medications are administered in accordance with prescribed orders.12. The expiration/beyond use date [the date by which one can use an opened or compounded/customized drug] on the medication label is checked prior to administering.

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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 safe medication labeling in accordance with accepted professional standards when Licensed Nurse (LN) 21 administered an opened and unlabeled inhaler mouthpiece to one of six residents (Resident 16) observed during medication administration. This failure had the potential for residents to receive the wrong inhaler, which could result in adverse resident outcomes, infections from accidental cross-contamination (germs), and medication errors.Findings:During a medication administration observation on 2/9/26 at 9:41 A.M., LN 21 was observed preparing and administering 13 medications to Resident 16. One of the administered medications was fluticasone/vilanterol (a medication for asthma or chronic obstructive pulmonary disease [COPD], respiratory conditions that affect breathing). The inhaler was inside a box that had the prescription label from the pharmacy, but the inhaler mouthpiece inside the medication carton did not have any labels attached to it.During a concurrent observation and interview with LN 22 on 2/9/26 at 4:35 P.M. outside of Resident 16's room, LN 22 stated there was no label on Resident 16's inhaler mouthpiece, but normally it would have a label affixed to it in addition to the label on the box.During an interview with the Director of Nursing (DON) on 2/11/26 at 9:26 A.M., the DON stated that nursing staff were expected to label the resident's name and open date on devices, such as inhaler mouthpieces.A review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised 11/22, indicated, .Labeling of medications.is consistent with.currently accepted pharmaceutical practices.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and facility document review, the facility failed to ensure that the Food Services Manager (FSM), who oversees the kitchen serving the skilled nursing facility, was qualified to manage the day-to-day operations of the food services department. This failure had the potential to negatively affect the health and well-being of 21 residents who received the food prepared in the kitchen.Findings:On 02/10/2026 at 11:50 AM, an interview was conducted with the Food Services Manager (FSM) and the Food Services Director (FSD). FSM stated shared responsibility with Food Services Director (FSD) for overseeing the kitchen that provides meals for the Skilled Nursing Facility (SNF), Independent Living, Assisted Living and Memory Care. FSM stated that she did not have the Certified Dietary Manager or the Dietary Services Supervisor credential. FSD agreed with the FSM statement of responsibilities. On 02/10/2026 at 3:56 PM, an interview was conducted with the Administrator (ADM) who confirmed that the current structure of the kitchen is that FSD and FSM oversee the entire community and the facility does not have a dedicated day-to-day qualified person full time for SNF. During the recertification survey from 02/09/26 to 02/12/26, multiple issues were found in the kitchen, including absence of cool down process for time and temperature control for food safety, improper use of gloves and uncovered facial hair.According to the California Code, Health and Safety Code - HSC S 1265.4, a licensed health facility shall employ a full-time, part-time, or consulting dietitian. A health facility that employs a registered dietitian less than full time, shall also employ a full-time dietetic services supervisor who meets the requirements of subdivision (b) to supervise dietetic service operations.Review of the facility's documents for qualifications of the FSM failed to show evidence she met the qualifications under the California Code, Health and Safety Code - HSC S 1265.4.On 02/10/2026 at 4:15 PM, an interview was conducted with ADM. ADM acknowledged the above findings.Cross references to F812 examples #1, #2, and #3.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, facility document review, and facility P&P review, the facility failed to prepare foods in a form designed to meet individual needs when facility recipes were not followed for fortified foods (foods that have nutrients added to them that were not originally present). These failures had the potential to result in decreased food and nutrient intake for 6 of 6 residents on fortified diets. Findings:On 02/10/2026 at 9:55 AM, a concurrent interview and document review was conducted with [NAME] (CK), Mexican Roasted Vegetable Recipe, undated, was reviewed. CK was asked how do you determine how to fortify foods for a Fortified Diet. CK stated that he uses 2 oz of gravy or butter. CK stated that it is listed on the recipe. When shown the recipe, CK couldn't locate where on the recipe the gravy or butter was listed. CK stated he plans to add butter to all items on the menu for the lunch meal. On 02/10/2026 at 9:50 AM, a concurrent interview and document review was conducted with the Food Services Director (FSD), High Calorie Fortified Diet, undated, was reviewed. FSD stated that the cooks use the Calorie Boosters that are listed on the document. FSD stated that the cooks decide how much of the calorie boosters to add and when. 02/11/2026 at 11:35 AM an interview was conducted with Register Dietitian Nutritionist (RDN). RDN stated that the menus use additions that are listed on the recipes. The cooks should follow the recipes to ensure the Fortified Diet is correct. RDN states she is recommending it for residents with weight loss or poor meal intake. A review of the facility's policy and procedure titled, Standardized Recipes, undated, indicated standardized recipes shall be developed and used in the preparation of foods. Only tested, standardized recipes will be used to prepare food. During a review of the facility's standardized recipe titled Mexican Roasted Vegetables, the recipe indicated Special Diet Instructions for Diabetic, Mechanical Soft Ground, Puree and Finger Food. Fortified diet was not listed on the recipe.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and facility document review, the facility failed to provide special required adaptive eating equipment (specially designed utensils and tools that help individuals eat more easily) for a resident during meals. This failure had the potential to negatively impact the health and well-being of one resident who received food prepared in the kitchen.Findings: On 02/09/2026 at 1:02 PM, a concurrent observation and interview was conducted with Resident 22 during lunch. Resident 22 had a meal tray at bedside. The tray ticket on the meal tray indicated plate guard (a removable device that attached to the edge of a plate to prevent food from sliding or spilling off while eating). The plate guard was not delivered on the meal tray. Resident 22 stated that there wasn't a plate guard on the meal tray. On 02/10/2026 at 12:15 PM, a concurrent observation and interview was conducted with Food Service Director (FSD) during lunch meal tray line. It was observed that Resident 22's tray ticket listed plate guard. Resident 22 did not have a plate guard on the meal tray. FSD confirmed that the plate guard was missing from Resident 22's meal tray and stated that it should have been included. A review of the facility's record titled, Order Summary Report, Food Preparation and Service, dated 02/10/26, indicated Resident 22 Dietary - Diet: Consistent Carbohydrate (CCHO).Plate guard for all meals.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain accurately documented records when the wrong indication (reason for taking a medication) was electronically transcribed on the Medication Administration Record (MAR, an official legal document that has a complete and accurate record of all medications administered to a resident to ensure patient safety) of one out of five sampled residents (Resident 5). This failure resulted in inaccurate documentation in Resident 5's medical records and had the potential to negatively affect the treatment and assessment of her medical conditions. Findings:During a concurrent interview and record review with Licensed Nurse (LN) 12 and the Medical Records Clerk (MRC) on 2/11/26 at 4:47 P.M., Resident 5's medical record was reviewed. The medical record indicated Resident 5 was on Namenda (a medication used to treat Alzheimer's disease, a condition that affects thinking, the ability to perform daily tasks and characterized by a loss of memory) 5 milligrams (mg, a unit of measure) two times a day for unconsolable crying, started 12/17/25. LN 12 was asked where the diagnosis came from. LN 12 pulled the original handwritten order, which read, Dx [diagnosis] unspecified dementia. LN 12 stated the incorrect diagnosis was inputted into the electronic medical record.A drug review of Namenda, provided by the facility, indicated Namenda was used for Moderate to severe Alzheimer dementia.A review of the facility's policy and procedure (P&P) titled, Charting and Documentation, undated, indicated, .3. Documentation in the medical record will be objective.complete, and accurate.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility's QAA/QAPI (Quality Assessment and Assurance/ Quality Assessment Program Improvement) committee failed to identify, develop, and implement action plans related to advance directives (cross reference F 578).This failure had the potential for residents not to have the opportunity to exercise their rights to formulate an advance directive.Findings: On 2/12/26 at 4:09 P.M., an interview was conducted with the director of nursing (DON) and the administrator (ADM). The ADM stated advance directives were not done according to the regulation for a lot of residents. Both the DON and ADM stated this should have been completed. The ADM stated the facility's QAPI committee looked into facility issues that affected a high number of residents. The ADM stated advance directives should have been identified as a project for the QAPI committee. A review of the facility's undated policy titled Quality Assurance and Performance Improvement (QAPI) - Feedback, Data and Monitoring, indicated, .information obtained about the quality of care and services delivered to residents is evaluated and monitored by the QAPI committee .to identify problems .high risk .and to guide decisions regarding opportunities for improvement .The QAPI process focuses on identifying systems and processes .problematic and could be contributing to avoidable negative outcomes related to resident care .resident choice

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement proper infection control practices in one of one Medication Rooms and in one of six sampled residents (Resident 7) when:The soap dispenser in the Medication Room was not working.Licensed Nurse (LN) 21 did not perform hand hygiene after touching a potentially contaminated surface during medication administration through a feeding tube (a surgically placed tube used to administer food and medications in individuals who have trouble swallowing) for Resident 7. These failures had the potential to put residents, staff and visitors at risk for infections due to cross-contamination.Findings:During a tour of the Medication Room on 2/9/26 at 10:22 A.M. with the Weekend Director of Nursing (WDON), an inspection of the Medication Room was conducted. Various waste bins were observed in the Medication Room, including two blue pharmaceutical waste bins (bins to discard expired, contaminated or unused drugs), a yellow chemotherapy (chemo, medications made of strong chemicals used to kill cancer cells, but can also destroy non-cancerous cells) waste bin, and a black RCRA (Resource Conservation and Recovery Act, for hazardous waste) bin. A sink, paper towel dispenser and soap dispenser were observed in the Medication Room. The soap dispenser with a motion detector was observed to have a blinking light and nothing came out when hands were placed underneath it.During an interview with the Infection Preventionist (IP) on 2/10/25 at 4:32 P.M., the IP stated there should have been soap at all sinks for handwashing to prevent staff who have touched medical waste from walking around the facility potentially contaminating things.A review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, revised 10/23, indicated, .3. Hand hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub, etc.) are readily accessible and convenient for staff use to encourage compliance with hand hygiene policies.During a concurrent medication administration observation and interview with LN 21 on 2/10/26 at 8:36 A.M., LN 21 was observed preparing and administering three medications through Resident 7's G-tube (gastrostomy tube, a feeding tube). Resident 7 had a sign that read Enhanced Barrier Precautions [EBP, infection control strategies used in nursing homes to prevent the spread of multidrug resistant organisms [MDROs], bacteria that cannot be killed by antibiotics]. outside her door.LN 1 wore a gown and gloves shortly before entering Resident 7's room for medication administration. LN 1 moved a bedside table while wearing gloves and then proceeded to administer Resident 7's medications through the resident's G-tube while wearing the same pair of gloves.LN 1 acknowledged she used the same gloves to move the bedside table and for medication administration. LN 1 stated she should have changed the gloves after moving the table to avoid cross-contamination.During an interview with the IP on 2/10/25 at 4:32 P.M., the IP stated the facility followed guidance from the Centers for Disease Control and Prevention (CDC, a national agency that provides instruction on public health issues) for EBP. The IP stated nursing staff were to change gloves after moving furniture to avoid touching the G-tube with contaminated gloves.A review of the CDC's resource on EBP, titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated, .PPE .refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities.A review of the facility's P&P titled, Enhanced Barrier Precautions, undated, indicated, .2.a. Gloves and gown are applied prior to performing the high contact resident care activity.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.g. device care or use (.feeding tube.).A review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 10/23, indicated, .Hand hygiene is indicated: a. immediately before touching a resident; b. before performing an aseptic task (.handing an invasive medical device).e. after touching the resident's environment.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that side rails were properly maintained for one out of one resident (Resident 14) when the resident's side rails were loose and unsteady.This deficient practice had the potential to result in the resident being entrapped in between the bed and the side rail.Findings: A review of Resident 14's admission Record indicated that the resident was admitted to the facility on [DATE] with diagnoses to include Unspecified Dementia (a condition characterized by memory loss and impaired judgement). On 2/09/26 at 9:20 A.M., an observation was conducted inside Resident 14's room. The resident's bed was observed to have an unpadded half side rail (an attached device to assist the resident with bed mobility) that was raised. The side rail was loose and easily moved from side to side and back and forth. The side rail had vertical bars with approximately 3-4-inch gaps in between. On 2/11/26 at 9:31 A.M., an interview was conducted with certified nursing assistant (CNA) 1. CNA 1 stated Resident 14 liked to go to the edge of the bed and attempted to get out of bed by climbing over the side rail. CNA 1 stated Resident 14 would also hang her legs over the side rails. On 2/11/26 at 2:24 P.M. a concurrent observation and interview were conducted with Licensed Nurse (LN)11 inside Resident 14's room. LN 11 was observed moving Resident 14's side rails. Both side rails moved back and forth and side to side. LN 11 stated Resident 14's side rails were very loose. LN 11 stated the side rails should not wiggle and should have been fixed to the bed. LN 11 stated Resident 14 could get hurt and that side rail needed to be more secure. LN 11 stated This is a concern. On 2/12/26 at 9:31 A.M., a joint interview and observation with the Maintenance Director (MD) was conducted while inside Resident 14's room. The MD stated she was called to the resident's room yesterday afternoon to check the side rails. The MD stated Resident 14's side rails were loose and that she tightened them both. The MD stated it was a safety issue if a side rail was loose. The MD stated nursing staff should have reported when the side rails became loose as they were the ones frequently raising and lowering Resident 14's side rails. The MD stated side rails were not routinely inspected after installation. The MD stated there was a work order system where staff could record a concern with a resident's side rails. The MD stated there were no reports regarding Resident 14's side rails since she installed them. On 2/12/26 at 1:44 P.M., an interview was conducted with the Director of Nursing (DON). The Administrator (ADM) and Director of Staff Development (DSD) were also present. The DON stated side rails should be monitored and should be firmly attached and secured to a resident's bed. The DON stated that loose side rails were not safe. A review of the facility's policy titled Hazardous Area, Devices and Equipment revised July 2017, indicated, .All hazardous areas, devices and equipment.will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible.identification of hazards.a hazard is defined as.that has the potential to cause injury or illness.examples.equipment and devices that are left unattended or are malfunctioning.devices and equipment that are improperly used or poorly maintained. A review of the facility's policy titled Bed Safety and Bed Rails revised August 2022, indicated, .6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks.8. Any worn or malfunctioning bed system.are repaired or replaced.