DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555711	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER: COMMUNITY CARE ON PALM		STREET ADDRESS, CITY, STATE, ZIP CODE: 4768 PALM AVENUE , RIVERSIDE, California, 92501	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the California Department of Public Health during a recertification survey conducted from April 13, 2026 through April 16, 2026. Survey findings included the investigation of one complaint: 2980091 Total resident census: 49 Total sampled residents: 14 No deficiencies were found for complaint number 2980091.	F0000		05/08/2026
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	F812 A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 04/13/2026, Cook #1 immediately donned a beard restraint and ensured it was properly secured. The Dietary Aide immediately adjusted the hairnet to fully contain all hair, including bangs/fringe, prior to resuming food service duties. Both staff members were re-educated on facility grooming and infection control standards related to safe food handling. On 04/13/2026, the opened unsealed bag of brown sugar was immediately discarded. All dry storage items were reviewed for labeling, dating, sealing, and proper storage. Any items identified as unlabeled, undated, damaged, or improperly stored were immediately corrected or discarded. On 04/17/2026, the Administrator and the Registered Dietician conducted an immediate inspection of the kitchen and food service areas. No evidence of resident illness, food contamination, or foodborne outbreak related to the cited deficient practice was identified. On 04/17/2026 the Licensed Nurses conducted visual observation of all residents for any signs or symptoms of gastrointestinal distress, nausea,	05/08/2026

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 reverse for further 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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F0812 SS = F	Continued from page 1 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. Cook 1 was performing food preparation without a beard restraint and the Dietary Aide had bangs exposed outside the hairnet while working in the kitchen. 2. The stovetop was covered with a thick, crusty layer of black and brown grease. 3. The interior and exterior surfaces of the oven were coated with heavy, dark buildup, exterior side of the oven door and its handle were coated with thick, heavy residue of old grease and dark deposits, and the bottom part of the oven was coated in a layer of sticky dust and oil residue. These failures had the potential to expose residents who received food from the kitchen to contaminants and could put them at risk of food-borne illnesses. 4. An opened, unsealed bag of brown sugar was found unlabeled and undated. This failure had the potential for the food product to go bad, become contaminated, or attract pests to the kitchen. Findings: 1. During an observation in the kitchen on 4/13/2026, at 7:53 AM, Cook 1 was performing food preparation without a beard restraint and the Dietary Aide had bangs exposed outside the hairnet while working in the kitchen. During an interview on 4/16/2026, at 8:24 AM, with the Assistant Dietary Services Supervisor (ADSS), ADSS stated kitchen staff should always be wearing hair nets and beard restraints properly. ADSS stated facility protocol required kitchen staff to have their hair completely covered. During a concurrent interview and record review on 4/16/2026, at 8:24 AM, with ADSS, the facility's undated Policy & Procedure (P&P) titled, "Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices" was reviewed. The P&P indicated, "Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens." ADSS stated that	F0812	Continued from page 1 vomiting, diarrhea, fever, or other concerns. No adverse findings were noted. On 04/27/2026 the stove, oven interior, oven exterior surfaces, handles, and surrounding affected kitchen equipment were deep cleaned, degreased, sanitized, and returned to a clean operating condition. B. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: On 04/17/2026 the Registered Dietitian and assistant dietary supervisor completed a comprehensive audit of all kitchen staff for compliance with hair restraints, beard restraints, hand hygiene, and sanitary food handling practices. On 04/17/2026 all food storage items were reviewed to ensure products were properly labeled, dated, sealed, rotated, and stored in accordance with facility policy and safe food handling standards. On 04/28/2026 a full kitchen sanitation audit was completed to inspect all cooking equipment, ovens, stovetops, food contact surfaces, dry storage, refrigerators, freezers, shelving, and small wares for cleanliness and sanitation. No other deficient findings identified during the audits. C. What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not recur: On 04/16/2026 the Administrator conducted an in-service education to dietary staff and cooks regarding: Proper use of hairnets, beard restraints, and personal hygiene during food preparation. Routine cleaning and sanitizing requirements for all kitchen equipment and food contact surfaces. Dry goods storage requirements, including sealing, labeling, dating, and stock rotation. Responsibility to immediately report sanitation	05/08/2026

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F0812 SS = F	Continued from page 2 kitchen staff should be wearing hair and beard nets properly at all times. 2. During a concurrent observation of the kitchen and interview on 4/13/2026, at 7:57 AM with ADSS, the kitchen stove was covered with a thick, crusty layer of brown and black grease. The ADSS confirmed the stove was covered with grease. 3. During a concurrent observation and interview on 4/13/2026 at 7:57 AM with ADSS, the interior and exterior surfaces of the oven were coated with heavy, dark buildup. The exterior side of the oven door and its handle were coated with thick, heavy residue of old grease and dark deposits, and the bottom part of the oven was coated in a layer of sticky dust and oil residue. The ADSS verified these findings and acknowledged that the oven surfaces had not been maintained and were coated with old grease and oil buildup. During a concurrent interview and record review on 4/13/2026, at 3:30 PM, with ADSS, the facility's undated P&P titled, "Sanitization" was reviewed. The P&P indicated, "All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions". The ADSS acknowledged the stove and oven required cleaning. 4. During a concurrent observation of the kitchen and interview on 4/13/2026, at 7:59 AM, with ADSS, an opened, unsealed bag of brown sugar was found unlabeled and undated. The ADSS confirmed the bag of brown sugar should be labeled and dated. A review of the facility's undated P&P titled, "Food Storage (Dry, Refrigerated, and Frozen)" indicated, "All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded."	F0812	Continued from page 2 concerns to the Dietary Manager and Administrator. On 04/17/2026 the facility developed and implemented a Dietary Sanitation / Food Safety Daily Audit Log (Food Procurement, Storage, Preparation & Service – Sanitary Compliance). This tool is utilized daily by the Dietary Supervisor or designee to conduct routine audits and ensure ongoing compliance with food safety and sanitation standards D. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur: Beginning 04/20/2026 the assistant Dietary Services Manager will conduct an audit weekly x 4 weeks, Monthly x 3 months or until substantial compliance is achieved using the Kitchen Sanitation & Food Safety Audit Tool to ensure compliance. Any findings will be addressed promptly. Audit results will be presented by the Administrator to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review trends, ensure sustained compliance, and implement additional interventions as necessary Date of completion: 05/08/2026	05/08/2026
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or	F0552	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal	05/08/2026

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F0552 SS = E	Continued from page 3 her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for five of five sampled residents (Residents 36, 53, 41, 21, and 1) on psychotropic (affecting brain activities associated with mental processes and behavior) medications. This failure had the potential for residents or their representatives to not be fully informed of the risks and benefits of psychotropic medications before receiving treatment. Findings: 1. A review of Resident 36's physician's orders indicated Resident 36 had orders for the following psychotropic medications: - Sertraline (generic for Zoloft, a psychotropic medication to treat depression) 50 milligrams (mg) by mouth one time a day for depression, dated 4/4/25; - Lorazepam (generic for Ativan, a psychotropic medication to treat anxiety) 0.5 mg by mouth two times a day for anxiety, dated 7/21/25 and 4/3/26; - Divalproex (generic for Depakote, a psychotropic medication to treat mood disorders) delayed release (DR) 1000 mg by mouth at bedtime for bipolar disorder (mood disorder that causes intense mood swings), dated 3/15/26; and - Trazodone (generic for Desyrel, a psychotropic medication to treat depression) 150 mg by mouth at bedtime for depression, dated 2/11/26.	F0552	Continued from page 3 and State Law. F552-Right to be informed/Make Treatment Decisions. How Corrective action will be accomplished for those residents found to have been affected by this practice. Resident #36-Informed consents for all the psychoactive medications were updated. For dates, please refer to the attachment of informed consents. On 4/3/26 Resident #53-Informed Consent for Risperdal was reviewed by [redacted] DNP. It did reflect the correct information with the exception of the date. On 4/13/26 Resident #41-Informed consents for all of the psychoactive medications were obtained and updated by [redacted] DNP On 4/14/26 Resident #21-Informed consent for Haldol was obtained and updated by [redacted] DNP On 3/28/26 Resident #1- Informed consent for Zyprexa was reviewed and adjusted for the increase in dosage by [redacted] DNP . How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All the residents in the facility have the potential to be affected. Based on the QAPI that the facility had developed in early March of 2026, all the residents who are on Psychoactive meds have been audited for current informed consents and all will be completed by May 9th, 2026. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur:	05/08/2026

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F0552 SS = E	Continued from page 4 During a concurrent interview and record review on 4/15/26 at 12:13 PM with the Director of Nursing (DON), Resident 36’s psychotropic informed consent forms, dated 9/21/24 to 1/12/25, were reviewed. The records indicated no evidence of informed consent for the ordered doses of sertraline, lorazepam, divalproex, or trazodone. The DON stated there were no additional informed consents for Resident 36. 2. A review of Resident 53’s physician’s orders, dated 11/26/25, indicated Resident 53 had orders for risperidone (generic for Risperdal, a psychotropic medication to treat mental illness) 1.75 mg by mouth at bedtime for schizophrenia (a mental illness characterized by disturbances in thought). During a concurrent interview and record review on 4/15/26 at 4:48 PM with the DON, Resident 53’s “Psychotherapeutic Drug Informed Consent Form,” dated 4/3/26, was reviewed. The record indicated informed consent for Resident 53’s risperidone was obtained on 4/3/26, after the date on the initial order. The DON stated this was the only informed consent the facility had for Resident 53. 3. A review of Resident 41’s medication administration record (MAR, daily documentation record used by nurses to document medications and treatments given to a resident), dated March 2026, indicated Resident 41 had orders for the following psychotropic medications: - Escitalopram (generic for Lexapro, a psychotropic medication to treat depression) 15 mg by mouth one time a day for depression, dated 12/2/25; - Lithium carbonate (a psychotropic medication to treat mental illness and mood disorders) 600 mg by mouth at bedtime for schizophrenia, dated 12/12/25; - Chlorpromazine (generic for Thorazine, a psychotropic medication to treat mental illness) 75 mg by mouth two times a day for schizophrenia, dated 12/2/25; and - Haloperidol (generic for Haldol, a psychotropic medication to treat mental illness) 10 mg by mouth two times a day for schizophrenia, dated 2/13/26. A review of Resident 41’s physician’s orders indicated additional orders for lithium carbonate, “Give 600 mg by mouth one time a day for	F0552	Continued from page 4 Licensed staff have been in-serviced on 4/1/26 - 5/1/26 by Director of Nursing regarding the process of completing Informed Consents for residents with Psychoactive meds. On 4/20/2026 The DON/Designee will review any new order for Psychoactive medication on a daily basis to ensure that : Documenting the informed consents are obtained verified to protect resident rights, promote safety, and facilitate appropriate use of the medications. Document the discussion, resident/representative understanding, and consent/refusal in the medical record. Initiation or dose increase; prescriber obtains the consent before administration. In addition, Medical records designee/MRD shall review/audit for compliance on monthly basis. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur. The Findings from the Medical records audit will be given to DON and presented to the monthly QAA committee for review and to ensure sustained compliance monthly for 3 months, then every 6 months, then annually until compliance is met and sustained. Completion Date :5/8/2026	05/08/2026

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F0552 SS = E	Continued from page 5 schizophrenia," dated 4/8/26. During an interview on 4/15/26 at 4:54 PM with the DON, the DON stated the facility did not have documented informed consent for Resident 41's psychotropic medications. 4. A review of Resident 21's physician's orders, dated 1/25/25, indicated Resident 21 had orders for haloperidol decanoate (generic for Haldol Decanoate, a long-acting injectable psychotropic medication given every four weeks to treat mental illness) 100 mg per milliliter (ml). During an interview on 4/16/26 at 8:18 AM with the DON, the DON stated the facility did not have documented informed consent for Resident 21's psychotropic medication. 5. A review of Resident 1's "NAQ – Psychotropic Assessment," dated 3/4/26, indicated the physician ordered Zyprexa (brand name for olanzapine, a psychotropic medication to treat mental illness) 10 mg injection every eight hours as needed for schizophrenia. A review of Resident 1's physician's orders, dated 3/17/26, indicated Resident 1 had additional orders for Zyprexa, "Inject 10 mg intramuscularly [into the muscle] every 8 hours as needed for schizophrenia." A review of Resident 1's "Psychotherapeutic Drug Informed Consent Form," dated 3/28/26, indicated informed consent for Resident 1's Zyprexa was obtained on 3/28/26, after the date on the initial orders. During an interview on 4/15/26 at 11:19 AM with the DON, the DON stated the facility needed to obtain informed consent before starting psychotropic medications for residents. The DON stated informed consent was supposed to be obtained for new psychotropic medication orders or whenever the dose was increased. A review of the facility's policy and procedure (P&P) titled, "Informed Consent for Psychotropic Drugs," undated, indicated:	F0552		05/08/2026

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F0552 SS = E	Continued from page 6 “This policy…outlines responsibilities for obtaining, verifying, and documenting informed consent to protect resident rights, promote safety, and facilitate appropriate use of these medications…” “This policy applies to all residents…prescribed psychotropic drugs, including new initiations, dose increases, or changes…” “Obtain informed consent for all psychotropic medications prior to initiation or dose increase…” “Document the discussion, resident/representative’s understanding, and consent/refusal in the medical record…” “Facility Role: Verify (but not obtain) informed consent; ensure documentation in the medical record...” and “Initiation or Dose Increase: Prescriber obtains consent before administration…” A review of the facility’s P&P titled, “Psychotropic Medication Use,” dated 1/6/25, indicated, “Informed Consent or Refusal…Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review…with the resident/representative prior to obtaining documented consent or refusal…”	F0552		05/08/2026
F0759 SS = E	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility had a medication error rate of 17.14% when six medication errors occurred out of 35 opportunities during the medication administration observation for four out of five residents (Residents 28, 7, 6, and 40). These failures resulted in medications not given according to the physician's orders and had the potential for residents to not receive the full therapeutic effect of medications.	F0759	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal and State Law. F759- Free of Medication Errors Rts 5 percent or more. How Corrective action will be accomplished for those residents found to have been affected by this practice.	05/08/2026

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F0759 SS = E	Continued from page 7 These failures also had the potential for blockages to develop in Resident 6’s gastrostomy tube (G-tube or feeding tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). Findings: 1. During a medication pass observation on 4/14/26, at 8:14 AM, at Resident 28’s bedside, Licensed Vocational Nurse 5 (LVN 5) was observed administering nine medications to Resident 28. The medications included two 125 milligram (mg) capsules of delayed release divalproex (generic for Depakote Sprinkles, a medication to treat mood disorders) for a dose of 250 mg. A review of Resident 28’s physician’s orders, dated 4/3/26, indicated Resident 28 had orders for “Divalproex Sodium Oral Tablet Delayed Release” (generic for Depakote, a medication to treat mood disorders), “Give 500 mg by mouth two times a day for Bipolar disorder [mood disorder that causes intense mood swings].” During an interview on 4/14/26, at 11:43 AM, with LVN 5, LVN 5 stated she gave 250 mg of divalproex capsules to Resident 28 during the morning medication pass. LVN 5 verified Resident 28 was supposed to get 500 mg of divalproex delayed release tablets. 2. During a medication pass observation on 4/14/26, at 8:27 AM, at Resident 7’s bedside, LVN 5 was observed administering nine medications to Resident 7. The medications included one 100 mg capsule of gabapentin (generic for Neurontin, a medication to treat nerve pain). A review of Resident 7’s physician’s orders, dated 3/16/26, indicated Resident 7 had orders for “Gabarone [brand name for gabapentin] Oral Tablet 100 MG,” “Give 100 mg by mouth two times a day for Nerve Pain.” During an interview on 4/14/26, at 11:31 AM, with LVN 5, LVN 5 stated she gave Resident 7 a gabapentin capsule during the morning medication pass. LVN 5 stated she was supposed to give Resident 7 a gabapentin 100 mg tablet.	F0759	Continued from page 7 Resident #28-Order for Divalproex was Reviewed. On 4/14/26 Residents received 250 mg instead of 500mg. MD was notified and informed the same day. No new orders and to continue with same dosage. No adverse reaction was noted from this. Resident #7- On 4/14/26 the order for Gabapentin tablet was changed to capsule as per MD order. There was no adverse reaction noted from resident receiving the capsule format vs. the tablet format. Resident #6- On 4/14/26 Resident’s MD was notified about the incorrect type of Iron supplement order. The order was clarified to Ferrous Sulfate Oral Solution 220mg/5ml give 7.5 ml via G-tube QD. instead of Glycinate. In addition, the MD was notified about resident not receiving Docusate. No new orders were given. Resident did not show any adverse reaction from missing this medication. LVN #5 – On 4/15/26 LVN 5 was in-serviced by DON regarding all prescribed medication will be administered correctly and in accordance with the prescribers order. Also to ensure that the correct formulation of medication, such as capsule vs. Tablet, will be administered correctly as prescribed by the MD. In addition, she was educated on proper way of administering medication via GT and the importance of flushing with 15 ml of water in between administration of each medication. Resident #40- On 4/14/26 the MD was notified about resident not receiving Seroquel at 4pm on 4/14/26. No new orders were given. Resident did not show any adverse effects from not receiving this dose. LVN#3- was in-serviced by DON on 4/15/26 regarding not omitting any scheduled medications that have been ordered. How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have potential to be affected by this	05/08/2026

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F0759 SS = E	Continued from page 8 During an interview on 4/15/26, at 10:03 AM, with LVN 4, LVN 4 stated nurses needed to call the physician before switching between dosage forms such as capsules and tablets. LVN 4 stated the physician could have ordered the specific dosage form because of a resident’s ability to “swallow” or another clinical reason. 3a. During a medication pass observation on 4/14/26, at 9:16 AM, at Resident 6’s bedside, LVN 5 was observed administering eight medications to Resident 6 through the G-tube. The medications included 7.5 milliliters (ml) of ferrous sulfate (iron supplement) 220 mg per 5 ml. A review of Resident 6’s physician’s orders, dated 3/17/26, indicated Resident 6 had orders for “Iron Oral Liquid (Iron Glycinate [iron supplement]),” “Give 7.5 ml via G-Tube one time a day for supplement.” During an interview on 4/14/26, at 11:25 AM, with LVN 5, LVN 5 stated she gave Resident 6 ferrous sulfate during the morning medication pass. LVN 5 stated Resident 6 had orders for iron glycinate, not ferrous sulfate. LVN 5 stated she did not give iron glycinate as ordered by the physician. During an interview on 4/15/26, at 10:35 AM, with the Director of Staff Development (DSD), the DSD stated nurses were expected to contact the physician to ask about changing the medication before administration. 3b. During a concurrent observation and interview on 4/14/26, at 9:16 AM, with LVN 5, outside Resident 6’s room, LVN 5 prepared eight medications for Resident 6’s medication pass. The medications included three liquids: ferrous sulfate, valproic acid (generic for Depakene, a medication to treat mood disorders), and levetiracetam (generic for Keppra, a seizure medication). LVN 5 verified she prepared three liquids for Resident 6’s morning medication pass. A review of Resident 6’s physician’s orders, dated 5/12/22, indicated Resident 6 had orders for docusate liquid (generic for Colace, a medication to treat constipation) 50 mg per 5 ml, “Give 10 ml via	F0759	Continued from page 8 practice. The residents’ medication administration records were reviewed by DON, and no other residents were affected by this practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur: Licensed were in-serviced by DON on 4/15/2-26 – 5/1/26 regarding medication administration of all medications orally and via GT based on facility pharmacy Policy and Procedures. DON/Designee will conduct a GT medication administration pass/check off weekly for the first month on random shifts. Then the Pharmacy consultant will come monthly for 6 months to audit GT medication administration. All the new orders shall be reviewed daily by clinical IDT members for correct dose, root, and diagnosis. The MRD shall audit for medication administration completion on daily bases to assure that compliance is achieved. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur. The DON shall review the weekly audits/ monthly audits and present any issues to monthly QAA meeting for further interventions to assure compliance every 3 months Completion Date :5/8/2026	05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555711	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER: COMMUNITY CARE ON PALM		STREET ADDRESS, CITY, STATE, ZIP CODE: 4768 PALM AVENUE , RIVERSIDE, California, 92501	

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F0759 SS = E	Continued from page 9 G-Tube two times a day for constipation.” During an interview on 4/14/26, at 11:25 AM, with LVN 5, LVN 5 stated Resident 6 was supposed to get docusate during the morning medication pass. LVN 5 stated the docusate was not given. 3c. During a medication pass observation on 4/14/26, at 9:16 AM, at Resident 6’s bedside, LVN 5 was observed administering eight medications to Resident 6 through the G-tube. LVN 5 first put 30 ml of water into Resident 6’s G-tube (also known as a G-tube flush). LVN 5 then administered each medication one at a time through the G-tube. LVN 5 did not flush the G-tube between each medication. After all medications were given, LVN 5 flushed the G-tube with 30 ml of water. During an interview on 4/14/26, at 10:04 AM, with LVN 5, LVN 5 stated G-tube medications were given one at a time. LVN 5 further stated the G-tube was supposed to be flushed before starting the G-tube medication pass and after all the medications were given. LVN 5 verified she did not flush the G-tube between each of Resident 6’s medications. During an interview on 4/15/26, at 10:43 AM, with the DSD, the DSD stated nurses were supposed to flush the G-tube with 10 ml of water between each medication during medication pass. The DSD stated flushing the G-tube between medications was important to prevent clogs. During a concurrent interview and record review on 4/15/26, at 12:30 PM, with the Director of Nursing (DON), the facility’s policy and procedure (P&P) titled, “Administering Medications through an Enteral [into the body through the mouth or feeding tube] Tube,” dated November 2018, was reviewed. The P&P indicated, “If administering more than one medication, flush with 15 mL warm purified water (or prescribed amount) between medications.” The DON stated nurses were supposed to flush the G-tube with water between each medication during medication pass. 4. During a concurrent interview and medication pass observation on 4/14/26, at 3:42 PM, outside Resident 40’s room, LVN 3 was observed administering five medications to Resident 40. The	F0759		05/08/2026

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F0759 SS = E	Continued from page 10 medications were one tablet each of divalproex extended release 500 mg, lisinopril (a medication to treat high blood pressure) 20 mg, metformin (a medication to treat diabetes) 1000 mg, olanzapine (an antipsychotic medication to treat mental illness) 10 mg, and sodium chloride (a supplement) 1 gram (gm, unit of measurement). LVN 3 verified she gave five medications to Resident 40 for the afternoon medication pass. A review of Resident 40’s physician’s orders, dated 3/23/26, indicated Resident 40 had orders for quetiapine (generic for Seroquel, an antipsychotic medication to treat mental illness) 200 mg, “Give 200 mg by mouth two times a day for Schizophrenia.” A review of Resident 40’s medication administration record (MAR, daily documentation record used by nurses to document medications and treatments given to a resident), dated April 2026, indicated Resident 40’s quetiapine was ordered to be given two times a day at 8:00 AM and 4:00 PM. During an interview on 4/14/26, at 4:58 PM, with LVN 3, LVN 3 stated she did not give quetiapine to Resident 40. LVN 3 stated she was supposed to give the medication during the afternoon medication pass. During an interview on 4/15/26, at 10:48 AM with the DSD, the DSD stated it was “always” the expectation for nurses to follow physician orders. During an interview on 4/15/26, at 12:20 PM, with the DON, the DON stated the nurse needed a reason to omit a medication and the nurse needed to notify the provider. A review of the facility’s P&P titled, “Administering Medications,” dated April 2019, indicated, “Medications are administered in accordance with prescriber orders.”	F0759		05/08/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence,	F0550	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal	05/08/2026

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F0550 SS = D	Continued from page 11 self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of six residents (Resident 47) was treated with dignity and respect when a Certified Nursing Assistant (CNA 1) stood over the resident while feeding her. This failure had the potential to cause diminished dignity, loss of individuality, and decreased psychosocial well-being during the dining experience for Resident 47. Findings:	F0550	Continued from page 11 Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal and State Law. F550-Resident Rights. How Corrective action will be accomplished for those residents found to have been affected: C.NA #1- was in-serviced 1:1 by the DON and DSD on 04/13/2026 regarding Residents Rights to treat them with respect and dignity when feeding residents by sitting down and providing the assistance at eye level. Each resident shall be cared for in a manner that promotes and enhances his or sense of well-being level of satisfaction with life, feeling of self-worth and self-esteem. Resident #47 – on 04/14/2026 resident was being assessed by the licensed nurse with regards to his rights as a resident that should be treated with respect and dignity when being fed. Resident has no concerns. How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All the residents have the potential of being affected by this deficient practice. The consequent meal observations revealed that no other residents were being affected by the same deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur: The Nursing staff were in-serviced by the DON and DSD on 04/13/2026-05/01/2026 regarding Resident's Rights to treat them with respect and dignity when feeding residents by sitting down and providing the assistance at eye level. Each resident shall be cared for in a manner that promotes and enhances his or sense of well-being level of satisfaction with life, feeling of self-worth and self-esteem. On 04/14/2026 the DSD and/or designee will	05/08/2026

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F0550 SS = D	Continued from page 12 A review of Resident 47's "Admission Record" (demographic clinical information) indicated the resident was admitted to the facility on 7/17/20 with diagnoses that included Cerebral Infarction, unspecified (blood clot cuts off blood flow to a part of the brain), Schizophrenia, unspecified (a brain disorder that causes people to interpret reality abnormally often resulting in disorganized thinking), and Depression. During an observation on 4/13/26, at 12:56 PM, in Resident 47's room, CNA 1 was observed feeding Resident 47 lunch while standing over the resident, who was seated in a wheelchair. CNA 1 continued to feed Resident 47 with a spoon while standing. During an interview with CNA 1 on 4/13/26, at 1:05 PM, CNA 1 stated she was expected to obtain a chair and sit while assisting Resident 47 with meals. CNA 1 further stated that sitting beside the resident at eye level was important for resident comfort. CNA 1 acknowledged she should have obtained a chair and been seated while feeding the resident. During an interview with the Director of Staff Development (DSD) on 4/13/26, at 2:25 PM, the DSD stated staff were expected to position themselves at the resident's eye level when providing feeding assistance. The DSD stated CNA 1 should have obtained a chair and sat beside Resident 47 while assisting with the meal to prevent the resident from feeling intimidated. A review of the facility's policy and procedure (P&P) titled, "Quality of Life-Dignity," indicated, "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being level of satisfaction with life, feeling of self-worth and self-esteem…1. Resident are treated with dignity and respect at all times…" A review of the facility's P&P titled, "Assistance with Meals," revised July 2017, indicated, "3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example…a. not standing over resident while assisting them with meals…"	F0550	Continued from page 12 conduct daily rounds to ensure continued compliance with the proper practice and report any deficient practice to DON. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur. The DON shall review compliance with the DSD rounds and report any deficient practiced to the monthly QAA committee to assure further and continued compliance monthly x 3 months then every 6 months and then annually until compliance is met and sustained. Completion Date :5/8/2026	05/08/2026
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect	F0605	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal	05/08/2026

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F0605 SS = D	Continued from page 13 and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from	F0605	Continued from page 13 Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal and State Law. F 605- Rights to be Free from Chemical Restraints How Corrective action will be accomplished for those residents found to have been affected: Resident #1- was evaluated by the prescribing MD and the Order for Zyprexa was renewed on 04/16/26 for 14 days until 04/30/26. How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All the residents have the potential to be affected by this deficient practice. On 04/15/2026, a review of all the residents on PRN psychoactive medications was conducted by DON. No other residents were found to be affected by this deficient practice. All the residents with Psychoactive medications had duration of therapy and were currently evaluated by the provider. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur: The licensed nurses were in-serviced by DON on 4/15-5/1/26 regarding the need for having duration of therapy for all PRN psychoactive medication and the need for prescriber’s evaluation at the time of renewal. All new orders for PRN psychoactive medications shall be reviewed during daily clinical meeting by IDT to assure compliance with this practice. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur.	05/08/2026

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F0605 SS = D	Continued from page 14 unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are	F0605	Continued from page 14 The IDT/DON shall report any non-compliance regarding this issue to monthly QAA committee to assure further continue compliance monthly for 3 months then every 6 months, then annually until compliance is met and sustained. Completion Date :5/8/2026	05/08/2026

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F0605 SS = D	Continued from page 15 limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 1) was free from unnecessary psychotropic medications (medications that affect brain activities associated with mental processes and behavior) when Resident 1 received an as needed antipsychotic medication (type of psychotropic medication) without physician evaluation. This failure had the potential for Resident 1 to inappropriately receive an as needed antipsychotic medication and had a risk of medication side effects, such as sedation and falls. Findings: A review of Resident 1’s admission record, dated 4/16/26, indicated Resident 1 was initially admitted to the facility on 1/22/26. The admission record indicated Resident 1’s diagnoses included schizophrenia (a mental illness characterized by disturbances in thought). A review of Resident 1’s physician’s orders, dated 3/17/26, indicated Resident 1 had renewed orders for Zyprexa (brand name for olanzapine, an antipsychotic medication to treat mental illness) 10 milligram (mg) injection, “Inject 10 mg intramuscularly [into the muscle] every 8 hours as needed for Schizophrenia [a mental illness characterized by disturbances in thought] m/b [manifested by] verbal/physical aggression for 14 Days.” During an interview on 4/16/26 at 2:35 PM with the Director of Nursing (DON), the DON stated there was no physician evaluation of Resident 1 for the renewed as needed (PRN) antipsychotic medication ordered on 3/17/26. The DON acknowledged the physician was supposed to evaluate Resident 1 before ordering the PRN Zyprexa. A review of the Prescribing Information (PI, detailed description of a medication available to clinicians) for Zyprexa injection, dated 2/11/26, retrieved from DailyMed, indicated “somnolence [sleepiness]” as an	F0605		05/08/2026

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F0605 SS = D	Continued from page 16 adverse reaction. A review of the facility's policy and procedure (P&P) titled, "Psychotropic Medication Use," dated 1/6/25, indicated, "PRN orders for psychotropic medications are limited to 14 days…For psychotropic medications that ARE antipsychotics: PRN orders cannot be renewed unless the attending physician or prescriber evaluates the resident and documents the appropriateness of the medication."	F0605		05/08/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by:	F0641	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal and State Law. F641-ACCURACY OF ASSESSMENTS How Corrective action will be accomplished for those residents found to have been affected: Resident #21- This resident GDR was considered on 2/13/26 by provider and stated that it was counter indicated. The MDS dated 2/25/26 was modified to reflect the consideration for GDR. Resident # 53-The MDS assessment of 3/2/26 was modified by the MDS coordinator to reflect the last GDR consideration by the MD was on 2/13/26. How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All the residents who are receiving psychoactive medications have potential to be affected by this deficient practice. The DON and MDS coordinator reviewed all the residents with psychoactive medications who have had any GDRs attempted or have been evaluated for GDRs and reviewed the MDS assessment to accurately reflect these GDRs. There were no other	05/08/2026

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NAME OF PROVIDER OR SUPPLIER: **COMMUNITY CARE ON PALM**		STREET ADDRESS, CITY, STATE, ZIP CODE: **4768 PALM AVENUE , RIVERSIDE, California, 92501**	

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F0641 SS = D	Continued from page 17 Based on interview and record review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS, a resident assessment tool) for two of five sampled residents (Residents 21 and 53). This failure had the potential for Residents 21 and 53 to not receive necessary care or services related to their antipsychotic medications (medications to treat mental illness). Findings: 1. A review of Resident 21’s MDS “Section N - Medications,” dated 2/25/26, indicated Resident 21 was receiving antipsychotic medication at the time of the assessment. The record further indicated the physician documented gradual dose reduction (GDR, stepwise tapering of a medication to determine if symptoms can be managed at a lower dose) of the antipsychotic was contraindicated on 8/14/23. During a concurrent interview and record review on 4/16/26 at 8:46 AM with the MDS Coordinator (MDSC), Resident 21’s “Plan of Care Note,” dated 2/13/26, and MDS Section N, dated 2/25/26, were reviewed. The MDSC stated the note indicated the prescriber documented GDR of Resident 21’s antipsychotics was contraindicated. The MDSC stated the GDR date on the MDS was incorrect and needed to be corrected. 2. A review of Resident 53’s MDS “Section N - Medications,” dated 3/2/26, indicated Resident 53 was receiving antipsychotic medication at the time of the assessment. The record further indicated the physician documented GDR of the antipsychotic was contraindicated on 9/14/23. During a concurrent interview and record review on 4/16/26 at 10:22 AM with the MDSC, Resident 53’s “Plan of Care Note,” dated 2/13/26, and MDS Section N, dated 3/2/26, were reviewed. The MDSC stated the note indicated the prescriber documented GDR of Resident 53’s antipsychotic was contraindicated. The MDSC stated the GDR date on the MDS was incorrect. During an interview on 4/16/26 at 10:42 AM with the MDSC, the MDSC stated the MDS was a “comprehensive” assessment of the resident at a specific point of time. The MDSC stated accuracy in	F0641	Continued from page 17 residents identified with having the same deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur: The MDS coordinator was in-serviced by DON on 04/17/2026 regarding reflecting the correct GDR status for all the residents reviewed each month. In addition, the list of all the residents reviewed for GDRs is to be made available to MDS coordinator by DON so that the correct GDR date can be reflected on MDS. The MDS coordinator to check for accuracy and to ensure that the MDS assessments for the residents who are due each month and to report any issues to the DON. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur. The DON shall report issues concerning accuracy of MDS assessments in Section N to monthly QAA committee for further review and intervention to ensure continued compliance monthly x 3 months then every 6 months and annually until compliance is met and sustained. Completion Date: 05/08/2026	05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555711	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026
NAME OF PROVIDER OR SUPPLIER: **COMMUNITY CARE ON PALM**		STREET ADDRESS, CITY, STATE, ZIP CODE: **4768 PALM AVENUE , RIVERSIDE, California, 92501**	

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F0641 SS = D	Continued from page 18 the MDS was important to “reflect accurate information” and to know whether services were being provided. The MDSC further stated incorrect information in the MDS could lead to needed services not being provided to the resident. During an interview on 4/16/26 at 10:58 AM with the Director of Nursing (DON), the DON stated the MDS was expected to be accurate. When asked why the MDS needed to be accurate, the DON stated an inaccurate MDS was not current for the resident’s care. A review of the facility’s policy and procedure (P&P) titled, “Comprehensive Assessments,” dated October 2023, indicated, “Comprehensive MDS assessments are conducted to assist in developing person-centered care plans” and “These assessments are used to develop, review and revise the resident’s comprehensive care plan.”	F0641		05/08/2026
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F0656	Plan of Correction – F656 Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) How corrective action will be accomplished for those residents found to have been affected by the deficient practice: On 4/15/26 The facility immediately corrected the deficient practice for Resident #32. Upon identification of the missing care plan following the unwitnessed fall on 4/13/2026, the Registered Nurse initiated a post-fall assessment A person-centered fall care plan, including individualized fall risk interventions, measurable goals, and monitoring parameters, was initiated and implemented in the resident’s medical record. Interventions included safety precautions, fall prevention strategies, staff monitoring, and resident-specific measures based on the identified cause and circumstances of the fall. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:	05/08/2026

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F0656 SS = D	Continued from page 19 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure an individualized care plan was developed when one of two residents (Resident 32) did not have a care plan for an actual fall. This failure had the potential to result in recurrent falls and serious injury due to lack of interventions to ensure Resident 32's safety following the initial fall event. Findings: 1. A review of Resident 32's "Admission Record." (a document showing a summary of the resident's information) dated 4/15/2026 indicated Resident 32 was admitted to the facility on 3/4/2026 with a diagnosis of abnormalities of gait and mobility. During an interview on 4/14/2026, at 8:23 AM, with Resident 32, Resident 32 stated "I fell." Resident 32 stated that he lost his balance and fell while getting out of bed on the previous day. A review of Resident 32's "Care Plan Report," undated, indicated there was no care plan problem related to Resident 32's fall incident on 4/13/2026. During a concurrent interview and record review on	F0656	Continued from page 19 On 4/15/26 , the Director of Nursing and MDS Coordinator, conducted a facility-wide audit of residents who experienced falls within the past 60 days to ensure that individualized short-term and/or comprehensive care plans were initiated, updated, and implemented timely following each fall incident. No other residents were affected by the deficient practice. What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not occur: On 4/15/26 - 5/1/26 , the Director of Nursing conducted an in-service education for licensed nurses, MDS staff, and interdisciplinary team members regarding the facility policy titled "Care Plans, Comprehensive Person-Centered" and "Falls and Fall Risk, Managing." Education included requirements for timely initiation and revision of care plans following falls, development of individualized interventions, documentation standards, implementation of interventions, and interdisciplinary communication. On 5/7/2026 The facility implemented a standardized "Post-Fall Care Plan Review Process" requiring licensed nurses to notify the MDS Coordinator/designee immediately following any actual fall event to ensure timely initiation or revision of the resident's care plan. Fall events are reviewed during daily clinical stand-up meetings to ensure care plan follow-through. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The DON or designee will conduct audits of residents with falls to verify that individualized short-term and/or comprehensive care plans were initiated or revised timely and that interventions were implemented as ordered. Audits will be conducted weekly for four (4) weeks, then monthly for three (3) months or until substantial compliance is achieved.	05/08/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **555711**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/16/2026**
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F0656 SS = D	Continued from page 20 4/15/2026, at 4:32 PM, with Licensed Vocational Nurse 6 (LVN 6) in the presence of Registered Nurse 1 (RN 1), Resident 32's "Care Plan Report," undated, was reviewed. LVN 6 and RN 1 confirmed Resident 32 had an actual unwitnessed fall on 4/13/2026 and did not have a care plan developed for the fall. During a concurrent interview and record review on 4/15/2026, at 4:52 PM, with the Minimum Data Set Coordinator (MDSC), Resident 32's "Care Plan Report," undated, was reviewed. The MDSC confirmed that no care plan was developed for Resident 32 following the fall on 4/13/2026. MDSC further clarified that a short-term care plan should have been documented and initiated by RN 1. A review of the facility's policy and procedure (P&P) titled, "Care Plans, Comprehensive Person-Centered," undated, 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 for each resident... 3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment". A review of the facility's P&P titled, "Falls and Fall Risk, Managing", undated, indicated, "Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling."	F0656	Continued from page 20 Any identified concerns will be addressed immediately through corrective action, re-education, and follow-up monitoring to ensure ongoing compliance. Audit results will be presented by the DON to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for three (3) months. The QAPI Committee will review trends, ensure sustained compliance, and implement additional interventions as necessary. Completion date: 5/8/26	05/08/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F0755	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal and State Law. F755-Pharmacy services/Procedures/Pharmacist/Records How Corrective action will be accomplished for those residents found to have been affected:	05/08/2026

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F0755 SS = D	Continued from page 21 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure accurate accountability of controlled medications (controlled substances [CS], those with high potential for abuse and addiction) when the Controlled Substance Records (CSR, accountability records) for one of three randomly selected residents (Resident 41) did not reconcile with the Medication Administration Records (MAR, daily documentation record used by a licensed nurse to document medications and treatments given to a resident). This failure resulted in inaccurate accountability of controlled substances and the potential for unidentified discrepancies and possible abuse or diversion of controlled substances. Findings: A review of Resident 41’s physician’s orders, dated 3/19/26, indicated Resident 41 had orders for tramadol (a controlled medication for pain) 50 milligrams (mg), “Give 1 tablet by mouth every 6 hours as needed for severe pain.” During a concurrent interview and record review on 4/14/26, at 4:10 PM, with Licensed Vocational Nurse 3 (LVN 3), Resident 41’s CSR, dated 3/20/26, and MAR, dated March 2026, were reviewed. The CSR indicated nursing staff removed one tablet of tramadol 50 mg on 3/24/26 at 7:48 AM and one on 3/27/26 at 8:05 AM. The MAR indicated tramadol was not administered to Resident 41 on 3/24/26 or 3/27/26. LVN 3 stated Resident 41’s MAR was missing documentation. LVN 3 stated it looked like the tramadol was not given to Resident 41 on	F0755	Continued from page 21 Resident #41-The Controlled Substance Record (CSR) for this resident was reviewed by DON on 04/14/2026. The count of Tramadol on the CSR matched the pill count in the med cart. Residents continue to use Tramadol for pain. How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All the residents in the facility have the potential to be affected by this deficient practice. The DON/Designee reviewed all the Narcotic sheets/CSRs against the medication administration record for month of April 2026. There were no other residents found to be affected with the same deficient practice. C-What measures will be put in place or what systemic changes will you make to ensure the deficient practice does not recur: The licensed staff was in-serviced by DON on 04/15/2026- 05/01/2026 regarding documentation of medication administration that administration of medication must be documented after (never before) it is given. That is required for all PRN medications including Narcotics. The DON conducted a 1:1 in-service to LVN3 on 04/16/2026 regarding facility’s policy on documentation of medication administration that administration of medication must be documented after (never before) it is given. The MRD shall conduct a weekly audit of Narcotic sheets in comparison to the documentation on the MARs to ensure compliance. The DON/Designee shall review these audits and intervene to ensure compliance. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur. The DON shall report the results of medical records audit to monthly QAA committee for review and to assure continued compliance monthly x 3 months then q 6months and then annually to ensure	05/08/2026

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F0755 SS = D	Continued from page 22 3/24/26 or 3/27/26. LVN 3 stated the medication administration needed to be documented on the MAR. During an interview on 4/15/26, at 10:07 AM, with LVN 4, LVN 4 stated nurses were supposed to verify the counts of controlled substances at each shift change to identify discrepancies. LVN 4 stated nurses were supposed to document administration of controlled substances in the CSR and the MAR. LVN 4 stated the CSR and the MAR “should match.” During an interview on 4/15/26, at 10:35 AM, with the Director of Staff Development (DSD), the DSD stated the expectation was for nurses to sign out the controlled medication on the CSR and to document the administration in the MAR. The DSD stated the purpose of narcotic accountability procedures was to identify discrepancies. During an interview on 4/15/26, at 10:55 AM, with the Director of Nursing (DON), the DON stated the nurse was supposed to document the removed tramadol in both the CSR and the administration in the MAR. A review of the facility’s policy and procedure (P&P) titled, “Documentation of Medication Administration,” dated April 2007, was reviewed. The P&P indicated, “Administration of medication must be documented immediately after (never before) it is given.”	F0755	Continued from page 22 compliance is met and sustained. Date of Completion: 05/08/2026	05/08/2026
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:	F0880	This Plan of Correction (POC) serves as our Credible Allegation of Compliance. Preparation and/or execution for this Plan of Correction does not constitute conclusions set forth in the Statement of Deficiencies. The facility will be in substantial compliance on or before 5/9/2026. The Plan of Correction is submitted as part of Federal Regulations. Title 42, Section 489.13, State Operations Manual, Section 2612 and California Health and Safety Code, Section 1280 and the facility does not waive its right to contest or pursue an appeal of the deficiency as allowed by the Federal and State Law. F880-Infection Prevention and Control How Corrective action will be accomplished for those residents found to have been affected:	05/15/2026

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F0880 SS = D	Continued from page 23 §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F0880	Continued from page 23 Resident #32 prefers to keep his urinal on his bedside table and has occasional blood in the urine due to his diagnosis of Malignant Neoplasm of bladder. This issue has been addressed with the resident, and he continues to refuse to allow staff to remove his urinal or place it in a different location. On 05/04/2026 the IDT conducted an IDT meeting with the resident to make him aware of the risk involved with infection control. Resident did not want to change his preference. How The facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All the residents have the potential to be affected by this deficient practice. On 05/04/2026 the IDT members reviewed other residents for similar issues, and no other residents were identified with the same deficient practice. What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur: The nursing staff have been in-serviced by DSD/DON regarding attempting/offering to remove the urinals from the bedside tables on 04/15/2026-05/01/2026. The charge nurses and/or IP nurse shall conduct daily rounds to assure compliance and report any findings to DON for further follow up. How the facility plans to monitor its performance to make sure the solutions are sustained and to ensure deficiency practice will not recur. The DON shall report any findings from the IP rounds to monthly QAA committee for further review to ensure continued compliance monthly x 3 months and then every 6 months and annually until compliance is met and sustained. Completion Date: 05/08/2026	05/15/2026

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F0880 SS = D	Continued from page 24 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to implement infection prevention and control practices to provide a safe and sanitary environment when a used urinal was found on one of 49 residents (Resident 32)'s bedside table. This deficient practice had the potential to expose residents to infection-causing substances in the facility. Findings: During an observation on 4/13/2026, at 9:23 AM, a urinal with bloody urine was found on Resident 32's bedside table next to a water pitcher. Bloody urine was observed on the outside of the urinal near the opening at the top and the lid was open. During an observation on 4/13/2026, at 3:20 PM, a urinal with bloody urine was found on Resident 32's bedside table next to a water pitcher and an empty food tray. Bloody urine was observed on the outside of the urinal near the opening at the top, and the lid was open. During an interview on 4/13/26, at 3:23 PM, with Certified Nursing Assistant 2 (CNA 2), CNA 2 verified the urinal with urine was on Resident 32's bedside table next to an empty food tray and confirmed the urinal should not be stored there. During a concurrent interview and record review on 4/16/2026, at 11:51 PM, with the Infection Preventionist (IP), the facility's undated policy and procedure (P&P) titled, "Policies and Practices - Infection Control" was reviewed. The P&P indicated, "This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections." The IP stated the policy was not followed when the urinal with bloody urine was found on Resident 32's bedside table.	F0880		05/15/2026