STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555141	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town & Country	555 East Memory Lane Santa Ana, CA 92706

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Potential for minimal harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the residents' rights to make choices about daily routines were honored for two of three final sampled residents (Residents 45 and 66) reviewed for choices. * The facility staff entered Residents 45 and 66's room during early morning hours while the residents were sleeping. The staff turned on the residents' room lights and moved their wheelchairs in the room without informing the residents. This failure had the potential to not to accommodate the residents choice.Findings: Review of the facility's P&P titled Promoting /Maintaining Resident Dignity revised 11/12/23, showed it is the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances residents' quality of life by recognizing each resident's individuality. Further review of the P&P showed as possible, the residents former lifestyle and personal choices will be considered when providing care and services to meet the resident needs and preferences. 1. On 9/23/25 at 1137 hours, an interview was conducted with Resident 66. Resident 66 stated on 9/22/25 at around 0730 hours, two staff members came into Residents 66 and 46's room while they were sleeping and abruptly moved things around, turned on the lights, and moved their personal items including the wheelchair without asking the residents. Resident 66 stated she preferred to continue to sleep in and was awakened by the facility staff. Resident 66 further stated one staff member closed the window and informed the residents the air conditioner was on and the residents were not allowed to open the window door. The same staff member abruptly closed the window. Resident 66 further stated the staff did not respect their rights and did not feel good about it. Medical record review for Resident 66 was initiated on 9/22/25. Resident 66 was admitted to the facility on [DATE]. Review of Resident 66' s H&P examination dated 9/4/25, showed Resident 66 had the capacity to understand and make decisions. Review of Resident 66's MDS assessment dated [DATE], showed Resident 66 was cognitively intact and required staff assistance for her activities of daily living. 2. On 9/23/25 at 1603 hours, an interview was conducted with Resident 45. Resident 45 stated on 9/22/25 at around 0730 hours, two staff members abruptly came into the room, moved things around, turned on the lights, and moved the wheelchairs which were close to the door while she and her roommate were sleeping. Resident 45 stated the staff did not ask her if they could turn on the lights and move the items in the room. Resident 45 stated she usually had a hard time falling asleep and wanted to continue sleeping. Resident 45 stated the staff did not greet her or say good morning. Resident 45 stated she felt invaded, the staff were rude, and the staff did not respect their rights. Medical record review for Resident 45 was initiated on 9/22/25. Resident 45 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 45's H&P examination dated 8/21/25, showed Resident 45 had the capacity to understand and make decisions. Review of Resident 45's MDS assessment dated [DATE] showed Resident 45 was cognitively intact and required staff assistance for her activities of daily living. On 9/23/ 25 at 1230 hours, an interview was conducted with CNA 5. CNA 5 stated she remembered entering Residents 45 and 66's room with LVN 13 on 9/22/25 at around 0730 hours. CNA 5 stated she and LVN 13 entered the room to prepare the residents for breakfast. CNA 5 further stated she knocked on the door before entering the room of Residents 45 and 66. CNA 5 stated LVN 13 turned on the residents' lights and moved the wheelchairs out of the way. CNA 5 further stated she did not remember if LVN 13 asked Residents 45 and 66 if she could turn on the lights and move the wheelchairs out of the way in the room. On 9/23/25 at 1243 hours, an interview was conducted with LVN 13. LVN 13 stated on 9/22/25 around 0730 hours, she and CNA 5 entered Residents 45 and 66's room. LVN 13 stated she turned the room lights on and moved the wheelchairs out of the way to prepare the residents for the morning. LVN 13 stated she did not ask the residents if she could turn on the lights and move the wheelchairs out of the way. LVN 13 further stated the residents in the facility have right to have a choice, and could continue to sleep if they chose to do so. LVN 13 stated she should have asked Residents 45 and 66 if she could turn the lights on and move the wheelchairs out of the way. On 9/25/25 at 1506 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON were informed and acknowledged the above findings.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 45) reviewed for unnecessary medications was free from unnecessary psychotropic medications. * Resident 45's medical record did not include the prescriber's clinical rationale for the continued use of the PRN (as needed) psychotropic medication. This failure had the potential for the resident to experience adverse effects for the use of the psychotropic medication. Findings: Review of the facility's Use of Psychotropic Drugs P&P revised 11/13/23, showed the PRN psychotropic medications extended beyond 14 days, the prescriber shall document the rational in the resident's medical record. Medical record review for Resident 45 was initiated on 9/22/25. Resident 45 was readmitted to the facility on [DATE]. Review of Resident 45's Order Summary Report showed the following physician orders:- dated 8/20/25, for Xanax (a psychotropic medication for anxiety) 0.25 mg by mouth PRN at night for anxiety. The order was completed on 9/3/25.- dated 9/4/25, for Xanax 0.25 mg by mouth PRN at night for anxiety.- dated 9/11/25, for 0.25 mg by mouth PRN at night for anxiety, until 9/18/25. - dated 9/21/25, for Xanax 0.25 mg by mouth PRN at night for anxiety, for 14 days. Review of Resident 45's medical record failed to show the prescriber documented their rationale and indication to exceed the 14 days duration for the PRN medication ordered. On 9/24/25 at 0722 hours, an interview and concurrent record review was conducted with the DON. The DON verified Resident 45's medical record failed to show the prescriber's clinical rationale for extending the Xanax medication PRN past 14 days.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to report an allegation of physical abuse to local law enforcement for one of three final sampled residents (Resident 32) investigated for abuse. * The facility failed to notify the law enforcement of Resident 32's allegation of a CNA being too rough with him. This failure had the potential to delay local law enforcement interventions related to the abuse allegation. Findings:Review of the facility's Abuse, Neglect, and Exploitation P&P revised 4/19/24, showed abuse allegations will be reported to the required agencies (e.g., law enforcement when applicable) no later than 24 hours (if the events that causes the allegation did not involve abuse and do not result in serious bodily injury. Review of the Welfare and Institutions Code section 15630 (b)(1)(A)(i & ii) showed all allegations of physical abuse, abandonment, abduction, isolation, financial abuse, or neglect, will be reported to local law enforcement both verbally, as soon as practically possible, and with a written report within 24 hours. Medical record review for Resident 32 was initiated on 9/22/25. Resident 32 was admitted to the facility on [DATE]. On 9/22/15 at 0900 hours, an interview was conducted with Resident 32 at his bedside. Resident 32 stated a CNA was too rough with him. The allegation was reported to the Administrator. Review of the facility's abuse investigation failed to show the local law enforcement was notified of the abuse allegation. On 9/25/25 at 0840 hours, an interview and concurrent medical record review was conducted with the Administrator. The Administrator stated Resident 32's allegation of a staff being too rough was considered a physical abuse allegation. The Administrator verified she did not notify local law enforcement and should have.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the abuse investigation protocol was followed for one of three final sampled residents (Resident 46) investigated for abuse. * Family Member 1 reported CNA 2 allegedly hit Resident 46. The facility failed to ensure CNA 2 was removed from the facility during the investigation of the abuse allegation. The failure had the potential to negatively impact Resident 46's well-being.Findings: Review of the facility's P&P titled Abuse, Neglect, and Exploitation revised on 4/19/24, showed the following:- it is the policy of this facility to provide protections for the health, welfare and rights of eachresident by developing and implementing written policies and procedures that prohibit andprevent abuse, neglect, exploitation and misappropriation of resident property;- existing staff will receive annual education through planned in-services and as needed;- responding immediately to protect the alleged victim and integrity of the investigation;- room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; and- protection from retaliation. Medical record review for Resident 46 was initiated on 9/23/25. Resident 46 was admitted to the facility on [DATE]. Review of Resident 46's H&P examination dated 8/14/25, showed Resident 46 had no capacity to understand and make decisions. Review of Resident 46's MDS assessment dated [DATE], showed Resident 46's Brief Interview for Mental Status (BIMS) score was 4, indicating severe cognitive impairment. Review of Resident 46's SBAR Communication Form dated 9/7/25, showed at 1840 hours, Family Member 1 reported CNA 2 hit Resident 46. The facility protocols were initiated and followed regarding the abuse allegation. CNA 2 was separately immediately and sent home. On 9/22/25 at 1249 hours, an interview was conducted with Family Member 1. Family Member 1 stated after she reported the allegation to LVN 1, CNA 2 was still able to enter Resident 46's room. Family Member 1 stated one of the nurses came in and instructed CNA 2 to leave Resident 46's room. In addition, Family Member 1 stated the facility should have made sure CNA 2 had no access to Resident 46 since it could cause the resident further emotional distress. On 9/24/25 at 1130 hours, a telephone interview was conducted with CNA 2. CNA 2 stated after she was instructed by LVN 1 to go home, CNA 2 went back to Resident 46's room and explained to Resident 46 and Family Member 1 the situation was a misunderstanding. CNA 2 stated LVN 1 had to escort her twice out of Resident 46's room. Furthermore, CNA 2 stated she expressed her apologies to the DON and DSD for not following facility's policies and procedures because she went to see Resident 46 after being instructed to leave the facility. On 9/24/25 at 1350 hours, an interview was conducted with the Administrator. The Administrator stated the facility's abuse policy and protocol in-service was provided to all the staff and verified it included the alleged staff perpetrator must leave the facility premises immediately to protect the alleged victim. On 9/24/25 at 1516 hours, an interview was conducted with LVN 1. LVN 1 stated after receiving report of the alleged incident from Resident 46's Family Member 1, LVN 1 went to inform and instruct CNA 2 to write a report, clock out, and leave the facility. LVN 1 stated CNA 2 went to the resident's room while she was making a copy of the report. LVN 1 went after CNA, however, CNA 2 was able to enter Resident 46's room and spoke with Resident 46 and Family Member 1. In addition, LVN 1 stated CNA 2 accessed Resident 46 and Family Member 1 twice after CNA 2 was instructed to leave the facility. LVN stated the priority was to protect and keep the alleged victim safe from the alleged perpetrator. LVN 1 stated the alleged perpetrator should be removed from the building. LVN 2 stated the negative outcome of failing to protect Resident 46 from the alleged perpetrator could be emotional distress. Furthermore, LVN 1 stated it is part of the abuse protocol and policy to remove the alleged perpetrator immediately out of the facility after an alleged abuse report. On 9/25/25 at 1023 hours, an interview was conducted with the DSD. The DSD stated the abuse in-services were provided on 5/22, 9/8, 9/22, and 9/23/25. The DSD stated she and the Administrator provided the abuse in-services, which included types of abuse and the facility's abuse P&P. The DSD stated all the staff received abuse in-service and were informed they must leave the facility immediately if any staff is involved in any type of abuse must leave the facility immediately and licensed nurses must make sure to protect the alleged victim from the alleged perpetrator at all cause immediately after receiving the abuse report. The DSD stated the priority of the licensed nurse was to remove the alleged perpetrator from the alleged victim and the facility premises to protect the residents. In addition, the DSD stated obtaining the report from the alleged perpetrator or involved staff could be completed the following day as part of the investigation and not mandatory to provide a copy of alleged perpetrator's statement or report immediately. On 9/25/25 at 1345 hours, an interview was conducted

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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 0656 Level of Harm - Potential for minimal 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, medical record review, and facility P&P review, the facility failed to develop the comprehensive person-centered plan of care to reflect the individual care needs for one of 18 final sampled residents (Resident 11). * The facility failed to ensure the comprehensive person-centered care plan for the use of bed rails was in place for Resident 11. This failure had the potential to cause inconsistent, inappropriate, and inadequate plans of care for Resident 11.Findings: Review of the facility's P&P titled Bed Rails revised on 11/12/24, showed the facility will continue to provide necessary treatment and care for the residents who have bed rails in accordance with professional standards of practice and the residents' choices. This should be evidenced in the residents' records, including their care plan. On 9/22/25 at 0903 hours, during the initial tour, Resident 11 was observed sitting up on the wheelchair and verbally responsive. Resident 11's bed was observed with the bilateral one-fourth bed rails elevated. Resident 11 stated when she was admitted to the facility, the bed rails were already on the bed. Medical record review for Resident 11 was initiated on 9/23/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 9/14/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11's BIMS score was 13, indicating cognitively intact. Review of Resident 11's medical record failed to show a care plan addressing Resident 11's bilateral one-fourth bed rails. On 9/22/25 at 0941 hours, an observation and concurrent interview was conducted with LVN 6. Resident 11 was observed sitting up on the wheelchair and verbally responsive. Resident 11's bed was observed with the bilateral one-fourth bed rails elevated. LVN 6 verified the above findings. LVN 6 stated Resident 11 used the bilateral one-fourth bed rails for repositioning while in bed. On 9/24/25 at 1545 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified Resident 11's bilateral one-fourth bed rails were on the resident's bed and elevated. The IP reviewed Resident 11's medical record and verified Resident 11's medical record failed to show a care plan was developed for Resident 11's bed rails. The IP stated the licensed staff must develop a care plan for Resident 11's bed rail to reflect the individual care needs for the resident. On 9/25/25 at 1345 hours, an interview was conducted with the Administrator and DON. The DON verified Resident 11 had the bilateral one-fourth bed rails in place. The DON stated a care plan must be developed by the licensed staff to reflect Resident 11's needs. The Administrator and DON were informed and acknowledged the above findings. Cross reference F700.

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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 0657 Level of Harm - Potential for minimal harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive care plan was revised for one of 18 final sampled residents (Resident 10). * The facility failed to ensure Resident 10's comprehensive care plan was revised to reflect when the physician's order for the apixaban (used to treat and prevent blood clots) medication was resumed. This failure placed the resident at risk of not being provided with the appropriate, consistent, and individualized care.Findings: Review of the facility's P&P titled Comprehensive Care Plans revised 11/29/23, showed it is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. Qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made. Medical record review for Resident 10 was initiated on 9/22/25. Resident 10 was readmitted to the facility on [DATE]. Review of Resident 10's H&P examination dated 12/4/24, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's physician's order dated 8/13/25, showed to resume apixaban 5 mg one tablet via GT every 12 hours for CVA prophylaxis. Review of Resident 10's plan of care showed a care plan problem revised 7/31/25, addressing the resident's risk for the signs and symptoms of the side effects of the apixaban medication. The care plan showed Resident 10 had a positive stool occult blood (blood in the stool) and the apixaban medication was on hold since 7/15/25. The interventions included holding the apixaban medication until further order. However, the apixaban medication was resumed by the physician on 8/13/25. On 9/24/25 at 0909 hours, an interview and concurrent medical record review was conducted with LVN 7. LVN 7 verified Resident 10 was given the apixaban medication every 12 hours at 0600 and 1800 hours. LVN 7 stated the care plan should have been revised when the physician ordered to resume the apixaban medication on 8/13/25. On 9/25/25 at 0857 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated the licensed nurse who received the physician's order should have updated the resident's care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to provide the services to attain or maintain the highest practicable well-being for one nonsampled resident (Resident 52). * Resident 52 was prescribed two medications to manage the BP. The facility failed to ensure a physician's order was obtained to monitor Resident 52's BP. This failure had the potential to negatively affect the resident's health condition and well-being. Findings: Review of the facility's P&P titled Vital Signs revised 5/12/23, showed the vital signs are indicators of health status, including temperature, pulse, blood pressure, respiratory rate, oxygen saturation. The vital signs shall be obtained at least in the following circumstances: at least weekly for a resident receiving custodial care, or non-skilled services. On 9/23/25 at 0804 hours, a medication administration observation for Resident 52 was conducted with LVN 4. LVN 4 administered the amlodipine (calcium channel blocker) and losartan potassium (antihypertensive) medications to Resident 52. LVN 4 did not check the resident's BP. Medical record review for Resident 52 was initiated on 9/23/25. Resident 52 was readmitted to the facility on [DATE]. Review of Resident 52's care plan for cardiac distress related to hypertension with CKD and CAD revised 5/20/24, showed interventions including monitoring the vital signs. Review of Resident 52's H&P examination dated 11/25/24, showed Resident 52 had the capacity to understand and make decisions. Review of Resident 52's Order Summary Report for September 2025 showed the following physician's orders:- dated 11/7/24, amlodipine (antihypertensive) 10 mg one tablet by mouth one time a day for hypertension (high BP)- dated 11/7/24, losartan potassium (antihypertensive) 50 mg one tablet by mouth one time a day for hypertension. Review of Resident 52's Weight and Vitals Summary for September 2025 showed the following:- dated 9/10/25 at 1042 hours, BP of 130/65 mmHg- dated 9/23/25 at 2348 hours, BP of 128/72 mmHg Further review of Resident 52's medical record failed to show a physician's order was obtained to check the resident's BP. Additionally, there was no documented evidence Resident 52's blood pressure was checked prior to receiving the amlodipine and losartan potassium medications on 9/23/25. On 9/24/25 at 1325 hours, an interview and concurrent medical record review was conducted with LVN 12. LVN 12 verified there was no physician's order to take the resident's BP while the resident was on the antihypertensive medications. LVN 12 stated Resident 52 should have had an order to take the BP prior to taking the antihypertensive medications because Resident 52 could be at risk for low BP. On 9/25/25 at 1343 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON were informed and acknowledged the above findings.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the appropriate care and services for one of one final sampled resident (Resident 29) reviewed for the use of the indwelling urinary catheter (a thin, hollow tube inserted through the urethra into the urinary bladder to collect and drain urine). * The facility failed to accurately monitor the fluid intake and output of Resident 29 related to the urinary catheter use as per the physician's order. The monitoring of Resident 29's urine output documented in the MAR (Medication Administration Record) did not match the CNAs documentation. In addition, the calculation of the daily total of Resident 29's urine output was inaccurate and in turn, the weekly calculation of Resident 29's urine output was also inaccurate. These failures posed the risk for the resident to have fluid imbalances resulting in kidney damage or heart failure, inadequate hydration leading to infection, and delayed detection of CAUTI (Catheter-Associated Urinary Tract Infection) or catheter obstruction, which could lead to sepsis (a serious condition in which the body responds improperly to an infection) and death. Findings: Review of the facility's P&P titled Intake and Output revised 10/29/24, showed the following:- To provide an accurate record of the residents' fluid intake and output;- The intake and output information are to be recorded at the end of each shift by the nursing staff. The 2300 to 0700 hours licensed nurse shall enter the 24-hour total daily; and- Weekly evaluations and end of intake and output evaluation are to be written by the 2300 to 0700 shift licensed nurses. On 9/22/25 at 0944 hours, 9/23/25 at 0800 hours, 9/24/25 at 0550 hours, and 9/25/25 at 0810 hours, Resident 29 was observed in bed and had an indwelling urinary catheter with the drainage bag observed hanging on the side of the bed. Medical record review for Resident 29 was initiated on 9/22/25. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Order Summary Report showed the following physician's orders dated 9/11/25:- For Foley catheter (type of indwelling urinary catheter) size French #16, to gravity drainage, for urinary retention(unable to urinate); and- To record the intake and output every shift, then record total amount on the 2300 to 0700 hours shift for 30 days. Weekly evaluation on the 2300 to 0700 hours shift every Mondays. Review of Resident 29's Task: B&B (Bowel and Bladder) - Catheter Care form showed the following documentation of Resident 29's urine output measurements:- on 9/6/25 at 0650 hours with 700 ml urine output, at 1453 hours with 800 ml urine output, and at 2028 hours with 300 ml urine output;- on 9/7/25 at 0659 hours with 300 ml urine output, at 1453 hours with 550 ml urine output, and at 2150 hours with 400 ml urine output;- on 9/8/25 at 0633 hours with 1200 ml urine output, at 1442 hours with 350 ml urine output, and at 2158 hours with 800 ml urine output;- on 9/9/25 at 0659 hours with 650 ml urine output, at 1433 hours with 400 ml urine output, and at 2210 hours with 400 ml urine output;- on 9/10/25 at 0625 hours with 800 ml urine output, at 1051 hours showed response not require, and at 2259 hours with 600 ml urine output;- on 9/11/25, showed response not required;- on 9/12/25, there was no documentation of the resident's urine output;- on 9/13/25 at 2101 hours with 800 ml urine output;- on 9/14/25 at 0659 hours with 400 ml urine output, at 1306 hours with 600 ml urine output, and at 2128 hours with 600 ml urine output;- on 9/15/25 at 0623 hours with 300 ml urine output, at 1407 hours with 850 ml urine output, and at 2256 hours with 500 ml urine output;- on 9/16/25 at 0659 hours with 400 ml urine output, at 1459 hours with 350 ml urine output, and at 2235 hours with 600 ml urine output;- on 9/17/25 at 0659 hours with 300 ml urine output, at 1435 hours with 300 ml urine output, and at 2236 hours with 200 ml urine output;- on 9/18/25 at 0659 hours with 800 ml urine output, at 1450 hours with 850 ml urine output, and at 2236 hours with 400 ml urine output;- on 9/19/25 at 0659 hours with 300 ml urine output, at 1400 hours with 750 ml urine output, and at 1823 hours with 800 ml urine output;- on 9/20/25 at 0623 hours with 1000 ml urine output, at 1427 hours with 600 ml urine output, and at 2242 hours with 400 ml urine output;- on 9/21/25 at 0614 hours with 1000 ml urine output, at 1419 hours with 900 ml urine output, and at 2048 hours with 500 ml urine output;- on 9/22/25 at 0554 hours with 500 ml urine output, at 1433 hours with 450 ml urine output, and at 2143 hours with 400 ml urine output;- on 9/23/25 at 0623 hours with 600 ml urine output, at 1415 hours with 600 ml urine output, and at 2223 hours with 300 ml urine output; and- on 9/24/25 at 0622 hours with 700 ml urine output, at 1228 hours with 550 ml urine output, and at 2152 hours with 700 ml urine output. Review of Resident 29's MAR for September 2025 showed the following documentation of Resident 29's urine output measurements:- on 9/6/25 at 0700 to 1500 hours shift with 800 ml urine output, at 1500 to 2300 hours with 300 ml urine output, and at 2300 to 0700 hours with 300 ml urine output. The daily output total was 1400 ml;- on 9/7/25 at 0700 to 1500 hours shift with 550 ml urine output, at 1500 to 2300 hours with 400 ml urine output, and at 2300 to

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Town & Country	555 East Memory Lane Santa Ana, CA 92706

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the physician's orders were clear and concise for one final sampled resident (Resident 32) investigated for intravenous care. * The facility failed to ensure Resident 32's physician's orders related to IV (Intravenous) care clearly indicated the IV access type as a PICC (Peripherally Inserted Central Catheter). This failure had the potential for the staff to not provide appropriate care for the resident's PICC line. Findings: Medical record review for Resident 32 was initiated on 9/22/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Order Summary Report showed the following physician's orders: - dated 8/22/25, for all blood draws through the PICC- dated 8/22/25, to change the administration set every day-shift- dated 8/22/25, to change the catheter site dressing every Friday, observe the site and note observations in a progress note. - dated 8/22/25, to change the catheter site dressing as needed with a transparent dressing. Observe the site and note observations in a progress note. - dated 8/22/25, to flush the IV with 10 ml normal saline before and after ceftriaxone (an antibiotic) medication administration.- dated 8/22/25, to flush the IV with 10 ml normal saline before and after daptomycin (an antibiotic) medication administration.- dated 8/22/25, to change the IV needleless connector as needed and after blood draws or transfusions.- dated 8/22/25, to change the IV needleless connector every Friday.- dated 8/22/25, the facility may use the catheter for blood draws. - dated 8/22/25, to measure the external catheter length PRN (as needed) and notify the physician if the length has changed. - dated 8/22/25, to measure the external catheter length every Friday and notify the physician if the length has changed. - dated 8/22/25, to monitor for signs and symptoms of infiltration/extravasation every shift. Resident 32's Order Summary Report further showed only one of the above 12 physician's orders specified the order was related to the resident's PICC. The remaining orders did not clearly specify the resident's IV access type as a PICC. On 9/24/25 at 0736 hours, an interview and concurrent medical record review was conducted with the DON. The DON stated Resident 32 had a PICC line. The DON reviewed Resident 32's physician's orders and stated the orders were not clear to show they were related to the PICC line. The DON stated there are multiple types of an IV access, and the orders should show the resident had a PICC line including if it was single or double lumen. The DON stated the catheter site and length could be confused to with a urinary catheter. The DON stated the nursing staff should have recognized the PICC orders were not clear, and clarified them with the physician.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for two of two final sampled residents (Residents 11 and 29) reviewed for respiratory care. * The facility failed to ensure Resident 11 and 29's nebulizer masks were properly cleaned after each use and stored when not in use. This failure had the potential for cross-contamination and increased risks of infection for Residents 11 and 29.Findings: 1. Review of the facility's P&P titled Nebulizer Therapy revised 8/12/23, showed the following: - The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway; and - The Steps in the Procedure section included: when treatment is complete, turn off the nebulizer and disconnect T-piece, mouthpiece and medication cup. Wash and dry hands. Rinse and disinfect the nebulizer equipment according to facility protocol, or wash pieces with water, and allow to air-dry on a paper towel. Wash and dry hands. When the equipment is completely dry, store it in a plastic bag with the resident's name and the date on it. On 9/24/25 at 0550 hours, during an observation, Resident 29 was in bed. Resident 29's nebulizer mask was connected to the nebulizer machine. The nebulizer mask was placed on top of a birthday card on the nightstand. The medication chamber attached to the nebulizer mask contained a clear liquid. Medical record review for Resident 29 was initiated on 9/22/25. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Order Summary Report showed a physician's order dated 8/28/25, to administer Albuterol Sulfate (bronchodilator) inhalation nebulization solution 3 ml inhale orally via a nebulizer every six hours as needed for shortness of breath or wheezing. On 9/24/25 at 0644 hours, an interview was conducted with LVN 8. When asked about the resident's nebulizer treatment, LVN 8 stated they did not really touch the nebulizer unless they must. LVN 8 stated they clean the nebulizer mask and medication chamber with soap and water, and leave them with a tissue paper to air dry after administering the nebulizer treatment. On 9/24/25 at 0730 hours, Resident 29 was observed sitting in a wheelchair. Resident 29's nebulizer mask was connected to the nebulizer machine. The nebulizer mask was placed on top of a birthday card on the nightstand. The medication chamber attached to the nebulizer mask contained a clear liquid. On 9/24/25 at 0731 hours, an observation for Resident 29 and a concurrent interview was conducted with LVN 9. LVN 9 verified Resident 29's nebulizer mask was placed on top of a birthday card on the nightstand, and the medication chamber attached to the nebulizer mask contained a clear liquid. LVN 9 verified there was also a pillowcase observed on the nightstand. LVN 9 stated the night shift nurses were supposed to clean the nebulizer mask with water and set it on top of a tissue paper to air dry. LVN 9 also stated the nebulizer mask could be set on top a pillowcase, as a barrier between the table. (continued on next page)

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/25/25 at 1055 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of the findings. The DON stated the charge nurses, not just the night shift nurses, should clean the nebulizer mask and the medication chamber with soap and water, then set these up on a tissue paper to dry. 2. On 9/22/25 at 0903 hours, during the initial tour, Resident 11 was observed sitting up in wheelchair. Resident 11's uncovered nebulizer mask was observed on top of the beside drawer and the plastic bag was touching the floor. Resident 11 stated she used the nebulizer treatment for chest congestion, and received a nebulizer treatment about three or four days ago. On 9/22/25 at 0941 hours, an observation and concurrent interview was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated it must have been the night shift nurse who left the nebulizer mask uncovered. LVN 6 stated the nebulizer mask must be placed in a bag and bag must not touch the floor to prevent germs. Medical record review for Resident 11 was initiated on 9/23/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's Order Summary Report for September 2025 showed an order dated 9/19/25, for ipratropium-albuterol (bronchodilator) inhalation solution 0.5-2.5 mg/3 ml, administer 3 ml orally via nebulizer every six hours as needed for shortness of breath or wheezing. On 9/25/25 at 1345 hours, an interview was conducted with the Administrator and DON. The DON stated after the licensed nurses have cleaned and dried the mask, it must be stored in a plastic bag. The Administrator and DON were informed and acknowledged the above findings.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of four final sampled residents reviewed for side rail use (Resident 11) remained free from the accident hazards associated with the use of elevated bed rails. * The facility failed to ensure the assessments, physician's order, care plan, and consent were completed and obtained for Resident 11's use of bed rails. These failures had the potential to put the resident at risk for entrapment and serious injuries.Findings: According to the FDA's Safety Alert entitled Entrapment Hazards with Hospital Bed Side Rails, residents most at risk for entrapment are those who are frail or elderly or those who have conditions such as agitation, delirium, confusion, pain, uncontrolled body movement, hypoxia, fecal impaction, acute urinary retention, etc., that may cause them to move about the bed or try to exit from the bed. Entrapment may occur when a resident is caught between the mattress and bed rail or in the bed rail itself. Inappropriate positioning or other care related activities could contribute to the risk of entrapment. Review of the facility's P&P titled Bed Rails revised on 11/12/24, showed the following:- as part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meet resident's needs;- the resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the residents' assessed needs;- the resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself;- informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner and given consent, voluntarily, free from coercion;- upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail;- The facility will ensure the correct installation and maintenance of bed rails, prior to use. This includes checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frames are compatible. Rails should be selected and placed to discourage climbing over rails. Ensuring that the bed's dimensions are appropriate for the resident by confirming that the bed rails are appropriate for the size and weight of the resident using the bed, installing bed rails using the manufacturer's instructions and specifications to ensure a proper fit, and inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; and- the facility will continue to provide necessary treatment and care for the residents who have bed rails in accordance with professional standards of practice and the residents' choices. This should be evidenced in the residents' records, including their care plan. On 9/22/25 at 0903 hours, during the initial tour, Resident 11 was observed sitting up in the wheelchair. Resident 11's bed had bilateral one-fourth bed rails present and were currently elevated. Resident 11 stated she used the bed rails for pulling up and repositioning while in bed, however, she was not assessed, and consent was not obtained from her. In addition, Resident 11 stated when she was admitted the bed rails were already present on the bed. On 9/22/25 at 0941 hours, an observation of Resident 11 and concurrent interview was conducted with LVN 6. Resident 11 was sitting up in wheelchair. LVN 6 verified Resident 11's bed had bilateral one-fourth bed rails present and were currently elevated. LVN 6 verified the above findings and stated Resident 11 used the bilateral one-fourth bed rails for repositioning while in bed. Medical record review for Resident 11 was initiated on 9/23/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 9/14/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's MDS assessment dated [DATE], showed Resident 11's BIMS score was 13, indicating the resident was cognitively intact. Review of Resident 11's Order Summary Report dated 9/23/25, failed to show a physician's order was obtained for the use of the bilateral one-fourth bed rails. Further review of Resident 11's medical record failed to show for the bed rail assessments, a physician's order, care plan, and consent were completed and obtained for Resident 11's use of the bilateral one-fourth bed rails. On 9/24/25 at 1545 hours, an interview and concurrent medical record review was conducted with the IP. The IP verified Resident 11's bilateral one-fourth bed rails were present and elevated. The IP verified Resident 11's medical records failed to show for the bed rail assessments, a physician's order, care plan, and consent were completed and obtained for Resident 11's use of the bilateral one-fourth bed rails. The IP stated the licensed staff must develop care plan for Resident 11's bed rail to reflect individual care needs. On

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 32) reviewed for unnecessary medications was free from unnecessary psychotropic medications. * The facility failed to ensure Resident 32's physician's orders were appropriate and properly clarified. This failure resulted in the prescriber's orders not being transcribed correctly in the resident's medical record and could have potentially lead to missed medication. Findings: Review of the facility's P&P titled Medication Orders revised 8/29/23, showed the nurse will transcribe handwritten physician's orders into the resident's electronic medical record. If necessary, the order should be clarified before the physician leaves the nursing station whenever possible. Medical record review for Resident 32 was initiated on 9/22/25. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's Order Summary Report showed a physician's order dated 9/15/25, to resume the residents aspirin (an antiplatelet medication) order when his antibiotics were completed or if his PTT (Partial Thromboplastin Time) was greater than 100 k. Review of Resident 32's NP Note/Follow Up Visit dated 9/15/25, showed the resident was on aspirin and Plavix (an anticoagulant), and had thrombocytopenia (low platelet count) possibly due to antibiotic therapy. The note further showed the resident's platelets were down to 79 (thous/mcl) and to discontinue aspirin and resume when the antibiotics were completed or the resident's platelets increased to greater than 100 k. Check weekly labs. Review of Resident 32's Lab Results Report dated 9/22/25, showed the resident's PLT Count was 104 thous/mcl. The reference range showed 150-400 thous/mcl. On 9/23/25 at 1006 hours, an interview and concurrent medical record review was conducted with RN 2. RN 2 stated Resident 32 was on aspirin 81 mg, which was discontinued on 9/15/25. RN 2 reviewed the transcribed order in the resident's EHR and stated the order showed to resume aspirin after antibiotics were completed, or when the resident's PTT was greater than 100 k. RN 2 stated there were no labs to show a PTT was completed, but as written, a PTT of 100 k did not make sense as it was way too high, and should have been clarified. RN 2 reviewed and verified the NP Note/Follow Up Visit dated 9/15/25, showed to resume when platelets were greater than 100 k, not PTT. RN 2 reviewed and verified Resident 32's laboratory results from 9/22/25, and stated the resident's platelets were 104 thous/mcl. RN 2 stated when the physicians or NPs do their rounds, they wrote their orders on a piece of paper and the nurse enters the orders into the EHR. RN 2 was unable to locate the paper and asked the medical records department for the paper. The medical records department provided an informal document titled Resident 32's written orders dated 9/15/25. The document showed it was unsigned and undated by the prescriber, and showed to discontinue the resident's aspirin and resume when antibiotics were completed or the PLT was greater than 100 k. RN 2 verified the order was entered incorrectly into the EHR. On 9/23/25 at 1116 hours, a telephone interview was conducted with NP 1. NP 1 stated she was not aware her written order was transcribed incorrectly, however she did review Resident 32's laboratory results on 9/22/25, and did not want to resume the resident's aspirin at this time. On 9/23/25 at 1118 hours, an interview was conducted with the DON. The DON stated the written order sheets were old order sheets used before using the EHR. The DON further stated the written order sheets were now used as a communication tool for orders, and should be treated like verbal orders.

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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, medical record review, and facility P&P review, the facility failed to provide the necessary pharmacy services to ensure the proper storage and disposal of the drugs and biologicals. * The facility failed to ensure safe storage of the medications when LVN 9 left medications on Resident 3's bedside table during medication administration observation. * The facility failed to ensure the bubble packs containing the gabapentin (anticonvulsant) tablets for Resident 3 and zolpidem (sedative medication) tablets for Resident 21 remained intact and free from tears inside Medication Cart B. * The facility failed to ensure safe storage of the medications when LVN 3 left medications on Resident 15's bedside table during the medication administration observation. * The facility failed to ensure the opened medication package was stored properly and an expired medication was disposed of in Medication Cart C. * The facility failed to ensure the temperature for the refrigerator containing intravenous and other medications requiring refrigeration was within the required range. These failures posed the risk for the residents to accidental ingestion, or unauthorized access to the medications left at bedside, and risk for receiving contaminated or ineffective medications due to the compromised packaging, expired medications, and inappropriate storage temperature.Findings: 1. Review of the facility's P&P titled Medication Storage dated 11/29/23, showed the following: - It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation and security. - All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls; - During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart; - Refrigerated Products: Temperatures are maintained within 36 to 46 degrees F. Charts are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee; and - Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective, or deteriorated medications with worn, illegible, or missing labels. On 9/23/25 at 0815 hours, a medication administration observation for Resident 15 was conducted with LVN 3. The medication cart was observed parked by the resident's doorway. LVN 3 prepared the following medications: - tramadol (opioid analgesic) 50 mg one tablet; - loratadine (antihistamine) 10 mg one tablet; (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- enoxaparin (anticoagulant) 40 mg injection; - duloxetine (serotonin and norepinephrine reuptake inhibitor) 20 mg one capsule; - hydroxychloroquine sulfate (antirheumatic) 200 mg one tablet; and - calcium 500 mg with vitamin D3 (supplement) one tablet. LVN 3 was observed placing all the prepared medications on a small tray and entering Resident 15's room. LVN 3 was observed placing the small tray with the medications on the bedside table. LVN 3 asked Resident 15 for her name and birthday and looked for the resident's identification bracelet but could not find it. LVN 3 went back to the medication cart, leaving the medications at the bedside unattended and unsupervised. Then LVN 3 came back and administered the oral medications to Resident 15. LVN 3 was then observed removing her gloves, and LVN 3 went by the door to use the alcohol-based hand rub and donned clean gloves. The enoxaparin injection was left at the bedside unattended and unsupervised. LVN 3 the came back and administered the enoxaparin injection to Resident 15. On 9/23/25 at 0901 hours, an interview was conducted with LVN 3. LVN 3 verified the above findings. 2. On 9/23/25 at 0828 hours, a medication administration observation for Resident 3 was conducted with LVN 9. The medication cart was observed parked by the resident's doorway. LVN 9 prepared Resident 3's oral medications, and other medications including: - fluticasone (corticosteroid) 50 mcg nasal spray; and - Trelegy Ellipta (respiratory inhalant) 200 mcg/62.5 mcg/25 mcg inhalation powder placed in an inhaler. LVN 9 was observed placing all the prepared medications on a small tray and entering Resident 3's room. LVN 9 administered the oral medications to Resident 3. LVN 9 was observed placing the small tray with the nasal spray and inhaler medications on the bedside table. LVN 9 removed her gloves and went by the door to use the alcohol-based hand rub and donned clean gloves. The nasal spray and the inhaler medications were left at the bedside unattended and unsupervised. Then LVN 9 went back to Resident 3 and administered the nasal spray, and the inhaler medications. LVN 9 went to the bathroom to throw away the cup with the water, which the resident used. The nasal spray and inhaler medications were left at the bedside unattended and unsupervised when LVN 9 turned her back on the medications while she was in the bathroom. When LVN 9 went back to the resident, LVN 9 was asked to check Resident 3's oxygen. After checking Resident 3's oxygen concentrator, LVN 9 went back to the medication cart, leaving the nasal spray and inhaler puff medications at the bedside unattended and unsupervised. Then LVN 9 came back to check Resident 3's oxygen saturation. On 9/23/25 at 0900 hours, an interview was conducted with LVN 9. LVN 9 verified the above findings. 3. According to FDA, it requires certain products to have tamper-evident packaging. A bubble pack is one such type of packaging, and the law requires it to be intact and sealed in a way that shows visible evidence if it has been opened or compromised. The seal that holds the plastic bubble to the backing material must be complete and intact all the way around. (continued on next page)

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Town & Country	555 East Memory Lane Santa Ana, CA 92706

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/22/25 at 1542 hours, an inspection of Medication Cart B was conducted with LVN 10. The following was observed: - The foil backing of the bubble pack containing gabapentin 300 mg for Resident 3 was not intact along the perforated line; and - The foil backing of the bubble pack containing zolpidem 5 mg for Resident 21 was previously torn open and taped over. LVN 10 verified the above findings. On 9/25/25 at 1113 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed of the above findings. 4. a. On 9/22/25 at 1601 hours, an inspection for Medication Cart C was conducted with LVN 2. During the inspection of Medication Cart C, the following was observed: - one opened individual pack of calcium alginate (wound dressing to absorb moderate to heavy wound exudate, form a moist, healing gel, and promote debridement). The package's description showed the medication was a single use only; and - one opened bottle of sterile water with an expiration date of 2/9/25. On 9/22/25 at 1609 hours, an interview was conducted with LVN 2. LVN 2 was asked about the facility's process when opening an individual pack supply. LVN 2 stated the individual packages were single use only and need to be discarded after the single use. LVN 2 verified the above findings. b. On 9/23/25 at 1418 hours, an inspection of Medication Room A was conducted with IP. During the inspection of Medication Room A, the temperature reading for the locked Refrigerator A was observed at 50 degrees F, and the following was observed inside the locked Refrigerator A: - one unopened ceftriaxone (antibiotic) 2 gram (50 ml), to administer the entire content intravenously over 30 minutes (100 ml/hr) every 24 for Resident 32. - one unopened daptomycin (antibiotic) 350 mg, to administer the entire content intravenously over 30 minutes every 24 for Resident 32. Review of the ceftriaxone medication package showed to store the medication at or below - 20 degrees C (Celsius) (-4 degrees F (Farenheit). Thaw at room temperature (25 degree C, 77-degree F) or under refrigerator (5 degrees C/41 degrees F) do not force thaw by immersion in water baths or by microwave irradiation. The thawed solution is stable for 21 days under refrigerator or 48 hours at room temperature. Do not refreeze. Review of the daptomycin medication package showed to store the medication at or below - 20 degrees C (-4 degrees F). Thaw at room temperature (25 degrees C, 77 degrees F) or under refrigerator (5 degrees C/41 degrees F) do not force thaw by immersion in water baths or by microwave irradiation. The thawed solution is stable 30 days under refrigerator or 48 hours at room temperature. Do not refreeze. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Refrigerator A's temperature and expired medication log showed to maintain the temperature between 36 – 46 degrees F (2-8 degrees C). The monitoring log for Refrigerator A showed the temperature readings from 9/1 – 9/23/25 between 38 – 40 degrees F. On 9/23/25 at 1429 hours, an interview was conducted with IP. The IP verified the above findings. On 9/25/25 at 1343 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings.

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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 0804 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food item served for two nonsampled residents (Residents 33 and 96) was palatable. * Residents 33 and 96 were served with dry shrimp scampi. This posed the risk of Residents 33 and 96 for decreased meal intake, which may contribute to inadequate nutrition and negatively impact their well-being. Findings: 1. Review of the facility's P&P titled Meal Quality and Temperature revised 1/2025 showed the food and drinks are palatable, attractive, and served at a safe and appetizing temperature to ensure resident satisfaction and to meet nutrition and hydration needs. Review of the facility's document titled 2025 Spring/Summer - Week 3 Service for 9/22/25, showed the lunch menu for Monday 9/22/25, included soup bean navy, shellfish shrimp scampi, white rice, broccoli lemon, and blueberry pie. Review of the facility's document titled Shellfish Shrimp Scampi (Shrimp Scampi) recipe showed to use 11 pounds and ten ounces of shrimp, two pounds of butter, 1 1/4 cups of lemon juice, with 7.2 cloves of garlic, 2 1/3 cup of parsley for 48 servings of the shrimp scampi. The preparation step included arranging the shrimp on sheet paper in a single layer and pouring garlic butter over the shrimp. After cooking, remove from the oven and toss with parsley. The recipe did not include how to serve the shrimp scampi. On 9/22/25 at 1235 hours, during the initial dining observation, Resident 33 was observed in the dining room, and the lunch meal served included the shrimp scampi. When asked about her lunch, Resident 33 stated she had not eaten yet because she was waiting for the sauce for the shrimp. Resident 33 stated she wanted butter for the shrimp. Review of Resident 33's meal ticket showed to included butter; however, the butter was not served with her lunch tray. On 9/22/25 at 1236 hours, LVN 2 was asked to assist Resident 33. LVN 2 verified there was no sauce served with the shrimp, and butter was not served to Resident 33. LVN 2 stated Resident 33 said earlier that it was lacking something like sauce, but the shrimp scampi did not come with a sauce. Resident 33 was observed staring at her plate, then pushing her plate aside. Resident 33 then started eating the blueberry pie. Medical record review for Resident 33 was initiated on 9/22/25. Resident 33 was admitted to the facility on [DATE]. Review of Resident 33's Order Summary Report showed a physician's order dated 8/29/25, for no added salt diet, regular texture with thin liquid consistency. 2. On 9/22/25 at 1337 hours, during the initial dining observation, Resident 96 was observed in her room, and the lunch meal served included the shrimp scampi. When asked about her lunch, Resident 96 stated lunch was good but the shrimp needed some sauce. It is just dry. When LVN 9 went into the room, Resident 96 asked LVN 9 for a shrimp sauce. LVN 9 verified the shrimp scampi was not served with a sauce. LVN 9 stated it was just dry shrimp, no sauce. On 9/22/25 at 1343 hours, LVN 9 went back to the room with packets of ketchup. LVN 9 stated she paged the kitchen for butter, but the kitchen staff did not respond, so she brought ketchup, just for some sauce for the shrimp. Medical record review for Resident 96 was initiated on 9/22/25. Resident 96 was admitted to the facility on [DATE]. Review of Resident 96's Order Summary Report showed a physician's order dated 9/16/25, for no restriction diet, regular texture with thin liquid consistency. On 9/25/25 at 0902 hours, an interview was conducted with the Executive Chef. The Executive Chef stated the shrimp scampi was cooked with butter and lemon juice with garlic and parsley. The Executive Chef stated he did not know why there was no sauce on the shrimp scampi, but it could be because it was served with the slotted spoon during the tray line services, which could have separated the shrimp from the sauce.

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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 provide only food in a form designed to meet the individual needs for one of 11 residents (Resident 45) receiving soft and bite sized diet (food that are soft, tender and moist throughout but with no separate thin liquid). *Resident 45 was served breakfast with Cheerios cereal added to the resident's meal tray. This failure had the potential to result in difficulty in swallowing, chewing, decrease in food and nutrient intake, resulting in possible unintended (not planned) weight loss and choking (when food gets stuck in the airway, blocking the flow of air to the lungs).Findings: Review of the International Dysphagia Diet Standardization Initiative (IDDSI) A global initiative that developed standardized terminology and definitions for texture-modified foods and thickened liquids used for individuals with dysphagia (difficulty swallowing) and chewing) guideline website titled IDDSI dated 7/2019 the IDDSI guideline showed, Level 6 Soft and Bite Sized is eaten with a fork, spoon or chopsticks, can be mashed/ broken down with pressure from a fork, spoon or chopsticks. cereal texture fully softened. Review of the facility's P&P titled Diet Orders and Other Resident Information revised 1/2025 showed Food and Nutrition Department: Plans and serves meals based on approved diet list and diet extensions/ spreadsheets. Review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled Soft and Bite Sized reviewed 9/23/25, showed the soft and bite sized diet can be eaten with a fork, spoon or chopsticks, can be mashed/ broken down with pressure from a fork, spoon or chopsticks.soft, tender and moist throughout but with no separate thin liquid. Review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled 2025 Spring/ Summer - Week 3, dated 9/22/25, showed the residents on soft and bite sized diets, for breakfast on 9/24/25, would include the following food on the breakfast tray:- Pears diced chopped SB6 (Soft and Bite Sized-a textured modified diet used for people who have difficulty chewing or safely managing regular food) four oz.- Cereal Oatmeal or Cream of Wheat six oz.- Egg Scrambled two oz.- Sausage Patty chopped SB6 two oz.- Slurried (semiliquid) Pancake two oz. or Slurried Toasted Wheat one portion On 9/24/25 at 0845 hours, an observation and concurrent interview was conducted with Resident 45. Resident 45 stated she was aware she was receiving a soft and bite sized diet per the physician's orders. Resident 45 stated was surprised that she had been given Cheerios cereals on her breakfast tray as requested. Resident 45 had handwritten the request on her meal ticket. On 9/24/25 at 0946 hours, an interview for Resident 45 was conducted with the RD. The RD stated Resident 45 should have not received the Cheerios with a SB6 diet order.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the food preferences were honored for one nonsampled resident (Resident 17) who received food prepared in the kitchen. * The facility served pork to Resident 17 during lunch when there was a physician's order for no pork, and resident's religious preference for no pork. This failure had the potential to negatively impact the resident's food intake and well-being. Findings: Review of the facility's P&P titled Resident Dining Profile and Food Preferences revised 1/2025 showed individual food and dining preferences incorporating religious, cultural, ethics, and portion sizes are obtained from residents and/or a resident representative(s) on a regular basis. Food and dining preferences will be obtained as soon as possible but not exceeding 72 hours after admission.Resident preferences include:- dining preferences;- dislikes;- allergies;- cultural, religious, and ethnic preferences;- mealtime preferences;- where they choose to eat their meals; and- with whom they choose to dine. Medical record review for Resident 17 was initiated on 9/22/25. Resident 17 was admitted to the facility on [DATE]. Review of Resident 17's H&P examination dated 9/23/25, showed Resident 17 had no capacity to understand and make decisions. Review of Resident 17's Order Summary Report showed a physician's order dated 11/9/23, for No restriction diet, Regular texture, thin liquid consistency, no pork. On 9/23/25 at 1244 hours, during lunchtime, an observation was conducted with Resident 17. Resident 17's lunch tray was observed with another resident's (Resident 24) name on the tray with three ounces of Char [NAME] pork barbecue, six fluid ounces chicken wonton miso soup, and Asian salad with dressing. On 9/23/25 at 1254 hours, an interview was conducted with LVN 2. LVN 2 stated she did not know why Resident 24's meal tray, which included pork, was served to Resident 17. On 9/24/25 at 0852 hours, an interview was conducted with Resident 17. Resident 17 stated that she was a Muslim and did not eat pork. On 9/25/25 at 0857 hours, an interview was conducted with the DON. The DON acknowledged the above findings.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the food safety and sanitation guidelines were followed. * Meat thawing process was not followed; * Expired food was not discarded; * Meal preparation equipment was not air dried; * The food preparation sink did not have backflow prevention; * Food preparation equipment was not clean; and * Cutting boards were stained and heavily marred. These failures posed the risk for food-borne illnesses in highly susceptible resident population of 82 facility residents who received food prepared in the kitchen.Findings: 1. According to USDA Food Code 2022, Section 3-501.13, freezing prevents microbial growth in foods, but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins. Review of the facility's P&P titled Food Handling Guidelines revised 1/2025 showed raw meat is removed from the freezer Day 1; it must be cooked by the end +4 days. Label with the date it was removed from the freezer, and the date by which it must be used. On 9/22/25 at 0829 hours, during initial tour of kitchen, an observation of the walk-in refrigerator and concurrent interview was conducted with the Executive Chef. The following items were observed: - Two 40-lbs. boxes of chicken thighs with no use by date or freezer pull date. The Executive Chef stated the food from the freezer in the process of thawing should be labeled with the use by date and the freezer pull date. The Executive Chef verified the above findings. On 9/22/25 at 1029 hours, during an observation of the walk-in refrigerator and concurrent interview with the RD. The RD verified the two 40-lbs. boxes of chicken thighs did not have a use by date or freezer pull date. 2. According to USDA Food Code 2022, Section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking the refrigerated, ready-to-eat time/temperature control for safety food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified. Review of the facility's P&P titled Food and Supply Storage revised 1/2025 showed open packages with unused portions should be covered, labeled and dated. Discard food past the use-by or expiration date. On 9/22/25 at 0829 hours, during initial tour of kitchen, an observation of the walk-in refrigerator and concurrent interview was conducted with the Executive Chef. The following items were observed: - An opened and sealed package of cheese, incorrectly labeled as Roll, Parmesan Focaccia with a facility expiration date of 9/21/25; and - An opened and sealed package of cheese, labeled as Cheese, Soft with a facility expiration date of 9/9/25. The Executive Chef verified the findings and stated the food should be discarded. 3. According to the USDA Food Code 2022, Section 4-901. 11, Equipment and Utensils, Air Drying Required, showed items must be allowed to drain and to air dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms. Review of the facility's P&P titled Storage of Pots, Dishes, Flatware, Utensils revised 1/2023 showed to air dry all food contact surfaces, including pots, dishes, flatware, and utensils before storage, or store in a self-draining position. Do not stack or store when wet. On 9/22/25 at 0829 hours, during the initial tour of kitchen with the Executive Chef, the blender was observed to be stored with water inside. The Executive Chef verified the findings and stated the equipment was not air-dried properly. 4. According to the USDA Food Code 2022, Section 5-402.11 Backflow Prevention, (A) a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. On 9/23/25 at 1215 hours, an observation and concurrent interview was conducted with the RD. The RD verified that there was a preparation sink without a proper air gap. On 9/24/2025 at 0915 hours, an interview was conducted with the Maintenance Director. The Maintenance Director verified there was not a proper air gap for the preparation sink. 5. According to the USDA Food Code 2022, Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, (A) Equipment, Food-Contact surfaces and utensils shall be clean to sight and touch. On 9/23/2025 at 1215 hours, an observation in the kitchen and concurrent interview was conducted with the RD. The RD verified there was a sheet pan that was stored in the kitchen on the shelf with other clean sheet pans and not clean with pieces of food stuck on it. 6. According to the USDA Food Code 2022, Section 4-501.12 Cutting Surfaces, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized or

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and facility P&P review, the facility failed to ensure the residents had the ability to store and reheat food brought from outside the facility. * There was no microwave or refrigerator available to use for the residents' food brought from outside the facility to be stored or reheat. This failure had the potential to negatively impact the resident's well-being.Findings: Review of the facility's P&P titled Use of Food Brought into the Facility revised 10/1/24, showed all the food items that are already prepared by the family or visitor brought in must be for immediate consumption. On 9/23/25 at 1415 hours, an interview was conducted with LVN 9. LVN 9 stated there was no microwave or refrigerator to use for the residents' food brought from outside the facility. LVN 9 stated if a visitor brought in food from outside the facility, it must be consumed right away. The facility did not store food or reheat food. On 9/23/25 at 1430 hours, an interview was conducted with RN 2. RN 2 stated there was no microwave or refrigerator available to use for residents' food brought from outside the facility to be stored. RN 2 stated she will verbalize to the family member they could keep their food from outside the facility at bedside for one to two hours. RN 2 stated she would make sure to check the resident's diet first and educate on the diet. On 9/23/2025 at 1045 hours, an interview was conducted during the Resident Council Meeting with Residents 31 and 60. Resident 60 stated the facility used to allow the residents to store food from outside the facility, but since the State (people conducting facility inspection) arrived, the kitchen could no longer store food from outside the facility. Resident 60 stated there was no separate refrigerator for the residents to store food from outside the facility. Resident 31 stated the kitchen could no longer store food from outside the facility. Resident 31 stated last year the facility would throw away the food brought by the family members or visitors to the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to implement the infection control practices designed to provide the safe and sanitary environment and help prevent the development and transmission of diseases and infections for one final sampled resident (Resident 7) and one nonsampled resident (Resident 96) reviewed for infection control. * The facility failed to ensure CNA 1 performed proper hand hygiene after providing incontinence and indwelling urinary catheter care to Resident 7. * The facility failed to ensure COTA 1 wore a gown when transferring Resident 96, who was on the EBP from the wheelchair to bed. These failures had the potential for cross-contamination and spread of infectious organisms throughout the facility. Findings: Review of the facility's P&P titled Hand Hygiene revised 4/21/24, showed the following: - Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice; - Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to before applying and after removing personal items, before and after handling clean or soiled dressings, linens, etc., before and after providing care to residents in isolation, before applying and after removing personal protective equipment (PPE), including gloves, after handling items potentially contaminated with blood, body fluids, secretions, or excretions, - Alcohol-based hand rub with 60 to 95% alcohol is the preferred method for cleaning hands in most clinical situations. Wash hands with soap and water whenever they are visibly dirty, before eating, and after using the restroom; When, during resident care, moving from a contaminated body site to a clean body site, after assistance with personal body functions (e.g., elimination, hair grooming, smoking), and when in doubt; and - The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 1. Medical record review for Resident 7 was initiated on 9/25/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 7/8/25, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's MDS assessment dated [DATE], showed Resident 7's Brief Interview for Mental Status (BIMS) score was zero, which meant the resident had severe cognitive impairment. Review of Resident 7's Order Summary Report dated 9/25/25, showed a physician's order dated 7/17/25, for Foley catheter (a thin, flexible tube inserted into the urethra (the tube that carries urine from the bladder to the outside of the body, to drain urine from the bladder) size 16 French/10 ml to gravity drainage every shift for wound management. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/25 at 1001 hours, an observation and concurrent interview for Resident 7 was conducted with CNA 1. CNA 1 was observed providing incontinence and indwelling urinary catheter care for Resident 7 with gown and gloves. After CNA 1 provided the care to Resident 7, CNA 1 placed a new brief to Resident 7 with the same gloves. CNA 1 verified she did not change gloves. CNA 1 stated the importance of changing dirty gloves and proper hand hygiene after incontinence and or indwelling urinary catheter care was to prevent the spread of infection. On 9/24/25 at 1054 hours, an interview was conducted with the IP. The IP stated the expectation for all the nurses after providing incontinence and indwelling urinary catheter care was for the nurses to doff dirty gloves and wash their hands. The IP stated the importance of proper hand hygiene was for the prevention of contamination and germs. In addition, the IP stated the facility had no limit on PPEs. Furthermore, the IP stated the nurses must change gloves if soiled or touching dirty areas. On 9/25/25 at 1345 hours, an interview was conducted with the Administrator and DON. The DON stated all the nursing staff must perform proper hand hygiene by removing dirty gloves after providing incontinence and indwelling urinary catheter care to the resident, wash their hands, and don new gloves, then resume providing resident's care. The Administrator and DON were informed and acknowledged the above findings. 2. Review of the CMS QSO-24-08-NH dated 3/20/24, for Enhanced Barrier Precautions in Nursing Homes to Prevent Spread of MDROs, showed MDRO transmission is common in long-term care facilities such as nursing homes, contributing to substantial resident morbidity and mortality and increased healthcare costs. Many residents in nursing homes are at increased risk of becoming colonized and developing infections with MDROs. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of MDROs that employ targeted gown and glove use during high-contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Review of the facility's P&P titled Enhanced Standard Precautions revised 5/28/24, showed the following: - Enhanced barrier precautions refer to the use of gown and gloves for certain residents during specific high-contact resident care activities that have been found to increase risk for transmission of multidrug-resistant organisms; - High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care: any skin opening requiring a dressing; and - Enhanced barrier precautions should be followed outside the resident's room when performing transfers and assisting during bathing in a shared/common shower room and when working with the residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/22/25 at 1254 hours, an EBP sign was observed posted outside Resident 96's room alerting anyone to perform hand hygiene before entering and when leaving the room. The sign also alerted the providers and staff to wear gloves and a gown for high-contact resident care activities. COTA 1 was observed inside the room transferring Resident 96 from wheelchair to bed. COTA 1 was wearing a mask and gloves but was not observed wearing a gown. On 9/22/25 at 1255 hours, an observation and a concurrent interview for Resident 96 was conducted with COTA 1. COTA 1 verified the above findings. COTA 1 stated Resident 96 was in the wheelchair, and he did not expect the resident to want to be transferred, so he just assisted her. When asked how he would know if a resident was on EBP, COTA 1 stated he did not see a catheter nor an IV on Resident 96, and he also checked his list. COTA 1 verified the EBP sign placed outside Resident 96's room. COTA 1 verified he transferred Resident 96 from the wheelchair to bed. COTA 1 verified he was only wearing a mask and gloves and did not wear a gown while providing a high-contact activity for Resident 96. Medical record review for Resident 96 was initiated on 9/22/25. Resident 96 was admitted to the facility 9/15/25. Review of Resident 96's Plan of Care showed a care plan problem dated 9/16/25, to address Resident 96's need for the EBP due to history of colonized MDRO. On 9/25/25 at 1011 hours, an interview was conducted with the IP. The IP stated when a resident was on EBP, the staff who provided the high-contact care activities, or anytime they have close contact to a resident on the EBP, should wear gloves and a gown.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and facility document review, the facility failed to maintain essential equipment in safe operating condition. * The facility failed to ensure two of two glucometers (a device which measures the amount of sugar in the blood) currently used and stored in Medication Carts A and B were properly calibrated. This posed the risk for inaccurate blood glucose test results used to determine the residents' insulin doses which could lead to inappropriate treatments and negatively affect the well-being of the residents. Findings: 1. Review of the EvenCare G2 Blood Glucose Monitoring System User's Guide dated 2017 showed the following: - Under Control Solution Testing section showed the purpose of the control solution testing is to make sure the EvenCare G2 meter and the EvenCare G2 test strips are working properly; - The Step 3 in performing a control solution test showed a ctl icon will appear next to the test strip and L1 will appear on the meter display screen; and - Under the Viewing Your Meter's Memory section showed control test results are flagged by ctl on the bottom left corner of the display screen in addition to MEM. Review of the facility's document titled Order Listing Report showed there were eight residents with orders for blood glucose level monitoring in Nurse Station A, where the glucometers in the Medication Carts A and B were used. On 9/22/25 at 1602 hours, an inspection of Medication Cart B, interview, and concurrent facility document review was conducted with LVN 10. Inspection of the medication cart showed the glucometer currently in use was EG970038, and a bottle of glucose test strip with Lot Number 16824112001, with a low range of 41 to 71, and high range of 164 to 222. The glucose test strips bottle was opened 9/21/25. Review of the facility's document titled Blood Glucose Quality Control Results Log for September 2025 for glucometer number EG970038 Cart 1, the glucometer test strip Lot Number was 16824112010, with a low range of 45 to 75, and high range of 168 to 228. LVN 10 verified the glucose test strip Lot Number with the low and high range numbers did not match the documentation in the Quality Control Log. 2. On 9/25/25 at 1021 hours, an inspection of Medication Cart A, interview, and concurrent facility document review was conducted with LVN 9. Inspection of the medication cart showed glucometer currently in use was EG870842. Review of the facility's document titled Blood Glucose Quality Control Results Log for September 2025 showed the serial number of the glucometer was EG743466 and did not match the serial number of the glucometer currently in use. When LVN 9 was asked to view the glucometer's memory to show the previous quality control test results, LVN 9 was observed checking the memory of the glucometer, but the display screen did not show the ctl icon from the previous test results. LVN 9 verified the glucometer currently in use did not match the glucometer number documented in the quality control test log, and there was no documentation to show a quality control test was performed for glucometer number EG870842. On 9/25/2025 at 1113 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON verified the above findings.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, medical record review, facility document review, and facility P&P review, the facility failed to ensure the residents' entrapment assessments were accurate and complete for 10 of 10 final sampled residents (Residents 1, 3, 7, 8, 10, 11, 29, 37, 43, and 58) reviewed for bed rails use. * The facility failed to ensure the entrapment assessment of bed rails were accurate and complete for Residents 1, 3, 7, 8, 10, 11, 29, 37, 43, and 58. These failures had the potential to negatively impact the residents resulting in possible entrapment, serious injury, and death. Findings: According to the Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, the term entrapment describes an event in which a patient/resident is caught, trapped, or entangled in the space in or about the bed rail, mattress, or hospital bed frame. Patient entrapment may result in deaths and serious injuries. These entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents, especially those who are frail, confused, restless, or who have uncontrolled body movement. The seven areas in the bed system where there is potential for entrapment are: - Zone 1: within the rail; - Zone 2: under the rail, between the rail supports or next to a single rail support; - Zone 3: between the rail and the mattress; - Zone 4: under the rail, at the ends of the rail; - Zone 5: between split bed rails; - Zone 6: between the end of the rail and the side edge of the head or foot board; and - Zone 7: between the head or foot board and the mattress end. Review of the facility's P&P titled Proper Use of Bed Rails dated on 8/2018 showed the facility to assess a resident's risk for entrapment prior to the installation of siderails or bedrails to ensure that the bed's dimensions are appropriate for the resident's size and weight. The facility will assess the resident's risk for entrapment for the use of a grab bar using the facility's grab bar assessment. This policy to reduce entrapment with the use of siderails has been developed utilizing the FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment. Review of the facility's P&P titled Bed Rails revised on 11/12/24, showed the following: As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bedrails meet resident's needs: (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the residents' assessed needs; - The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself; - Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion; - Upon receiving informed consent, the facility will obtain a physician's order for the use of the specified bed rail and medical diagnosis, condition, symptom, or functional reason for the use of the bed rail; - The facility will ensure the correct installation and maintenance of bed rails, prior to use. This includes checking with the manufacturer(s) to make sure the bed rails, mattress, and bed frames are compatible. Rails should be selected and placed to discourage climbing over rails. Ensuring that the bed's dimensions are appropriate for the resident by confirming that the bed rails are appropriate for the size and weight of the resident using the bed, installing bed rails using the manufacturer's instructions and specifications to ensure proper fit, and inspecting and regularly checking the mattress and bed rails for areas of possible entrapments; and - The facility will continue to provide necessary treatment and care for the residents who have bed rails in accordance with professional standards of practice and the residents' choices. This should be evidenced in the residents' records, including their care plan. 1. Medical record review for Resident 7 was initiated on 9/25/25. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 7/8/25, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated 9/25/25, showed a physician's order dated 7/7/25, for bilateral one-fourth bed rails in place to assist with bed mobility. On 9/23/25 at 0902 hours, an observation and concurrent interview for Resident 7 was conducted with the IP. Resident 7 was observed asleep in bed with bilateral one-fourth bed rails elevated. The IP verified the above findings and stated Resident 7 used the bed rails for repositioning. Review of Resident 7's Bed Rail and Mattress Safety assessment dated [DATE], showed Zones 1 to 6 were assessed; however, further review of the assessment showed no documented evidence Zone 7 was assessed (distance between head/foot board and the mattress end). On 9/25/25 at 0948 hours, an interview and concurrent record review was conducted with the Maintenance Staff. The Maintenance Staff verified the above findings. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Medical record review for Resident 11 was initiated on 9/23/25. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's H&P examination dated 9/14/25, showed Resident 11 had the capacity to understand and make decisions. Review of Resident 11's Order Summary Report dated 9/23/25, failed to show a physician's order for bilateral one-fourth bed rails. On 9/22/25 at 0903 hours, during the initial tour of the facility, Resident 11 was observed sitting up in wheelchair. Resident 11's bed was observed with bilateral one-fourth bed rails elevated. Resident 11 stated she used the bed rails for pulling up and repositioning while in bed. Resident 11 stated when she was admitted , the bed rails were already present in the bed. On 9/22/25 at 0941 hours, an observation and concurrent interview for Resident 11 was conducted with LVN 6. Resident 11 was observed sitting up in wheelchair and her bed was observed with bilateral one-fourth bed rails elevated. LVN 6 verified the above findings. LVN 6 stated Resident 11 used the bilateral one-fourth bed rails for repositioning while in bed. On 9/24/25 at 1545 hours, an interview and concurrent medical record review for Resident 11 was conducted with the IP. The IP verified Resident 11's bilateral one-fourth bed rails were elevated in bed. The IP verified Resident 11's medical record failed to show an entrapment assessment for the use of bed rails was conducted. On 9/25/25 at 0948 hours, an interview and concurrent facility document review was conducted with the Maintenance Staff. The Maintenance Staff was asked to review Resident 11's Bed Rail and Mattress Safety Assessment. The Maintenance Staff stated he did not receive a request for Resident 11 through facility's life loop application (a phone application where the nursing staff can request bed rails application and removal) from the nurses for bed rail application. In addition, the Maintenance Staff stated he did not complete Resident 11's Bed Rail and Mattress Safety Assessment. The Maintenance staff verified the above findings. 3. Medical record review for Resident 37 was initiated on 9/23/25. Resident 37 was readmitted to the facility on [DATE]. Review of Resident 37's H&P examination dated 6/2/25, showed Resident 37 had the capacity to understand and make decisions. Review of Resident 37's Order Summary Report dated 9/25/25, showed a physician's order dated 6/2/25, for bilateral one-fourth bed rails in place to assist with bed mobility. On 9/22/25 at 0915 hours, during the initial tour of the facility, Resident 37 was observed sitting up in wheelchair. Resident 37's bed was observed with bilateral one-fourth bed rails elevated. Resident 37 stated he used the bed rails for repositioning. On 9/22/25 at 0935 hours, an observation and concurrent interview for Resident 37 was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated Resident 37 used the bed rails for repositioning. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 37's Bed Rail and Mattress Safety assessment dated [DATE], showed Zones 1 to 6 were assessed; however, further review of the assessment showed no documented evidence Zone 7 was assessed. On 9/25/25 at 0948 hours, an interview and concurrent record review for Resident 37 was conducted with the Maintenance Staff. The Maintenance Staff verified the above findings. 4. Medical record review for Resident 58 was initiated on 9/23/25. Resident 58 was admitted to the facility on [DATE]. Review of Resident 58's H&P examination dated 7/2/25, showed Resident 58 had no capacity to understand and make decisions. Review of Resident 58's Order Summary Report dated 9/25/25, showed a physician's order dated 7/21/25, for bilateral one-fourth bed rails in place to assist with bed mobility. On 9/22/25 at 0850 hours, during the initial tour of the facility, Resident 58 was observed sitting up in wheelchair. Resident 58's bed was observed with bilateral one-fourth bed rails elevated. Resident 58 stated he used the bed rails for repositioning and bed transfers. On 9/22/25 at 0930 hours, an observation and concurrent interview for Resident 58 was conducted with LVN 6. LVN 6 verified the above findings. LVN 6 stated Resident 58 used the bed rails for repositioning. On 9/25/25 at 0948 hours, an interview and concurrent facility document review was conducted with the Maintenance Staff. The Maintenance Staff was asked to review Resident 58's Bed Rail and Mattress Safety Assessment for entrapment. The Maintenance Staff stated he could not find Resident 58's Bed Rail and Mattress Safety Assessment. The Maintenance Staff was asked about the process of the bed rails application. The Maintenance Staff stated he received request for bed rails application through the facility's life loop application. After the Maintenance Staff received the request for the bed rails, he stated he would apply the requested bed rails then check for entrapment. The Maintenance Staff stated he would use a device to check for entrapment. In addition, the Maintenance Staff stated he would assess the bed rails for entrapment every quarter after he received the request via life loop. Review of Resident 58's Bed Rail and Mattress Safety Assessment forms for entrapment conducted with the Maintenance Staff showed Zones 1 to 6; however, Zone 7 was not shown on the form. Furthermore, the Maintenance Staff verified the above findings and stated he did not assess Zone 7 for entrapment since it was not shown on all the Bed Rail and Mattress Safety Assessment forms. On 9/25/25 at 1345 hours, an interview was conducted with the Administrator and DON. The DON stated if it was not documented, it was not done. The Administrator stated Resident 58's bed rail work order was completed; however, the Maintenance Staff could not find the Bed Rail assessment form for entrapment. The DON stated the MDS nurses reassessed bed rails quarterly to check for appropriateness. The DON stated Medical Records staff checked and audited all documents for completion Monday through Friday, however, the DON and the assigned licensed nurses check for accuracy. The Administrator and DON were informed and acknowledged the above findings. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On 9/22/25 at 0902 hours, an observation and concurrent interview for Resident 1 was conducted. Resident 1 was observed lying in bed with bilateral one-fourth bed rails in place and elevated. Resident 1 sated she used the siderails for turning and repositioning. On 9/23/25 at 0901 and 1123 hours, Resident 1 was observed awake in bed with bilateral upper one-fourth bed side rails elevated. On 9/24/25 at 1343 hours, an observation and concurrent interview for Resident 1 was conducted with the LVN 2. LVN 2 verified the bilateral one fourth bed rails were elevated for Resident 1. LVN 2 stated Resident 1 used the bed rails bars to hold on to for turning and repositioning. Medical record review for Resident 1 was initiated on 9/22/25. Resident 1 was admitted to the facility on [DATE]. Review of Resident 1's H&P examination dated 7/17/25, showed Resident 1 had the capacity to understand and make decisions. Review of Resident 1's MDS dated [DATE] showed Resident 1 was cognitively intact and was dependent on the staff for her activities of daily living. Review of Resident 1's Order Summary Report showed a physician's order dated 7/17/25, for bilateral one-fourth bed rails to assist with bed mobility. Review of Resident 1's Care Plan Dated 7/17/25, showed addressing the use of one-fourth bed rails. The interventions included to perform bed rails safety check quarterly and as needed by maintenance. Review of Resident 1's Bed Rail/Mattress Safety assessment dated [DATE], did not show if Zone 7 was measured. On 9/5/25 at 0931 hours, an interview and concurrent medical record review for Resident 1 was conducted with the Maintenance Staff. The Maintenance Staff stated he applied the bed rails, and he measured the entrapment Zones 1 to 6. The Maintenance Staff verified the above findings. The Maintenance Staff was asked if he measured Zone 7 for the use of the side rails for Resident 1, he stated the Bed Rail/Mattress Safety Assessment from that facility used did not show to measure Zone 7, so he did not measure Zone 7. On 9/25/25 at 1506 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON were informed and acknowledged the above findings. 6. Medical record review for Resident 3 was initiated on 9/22/25. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's H&P examination dated 6/27/25, showed Resident 3 had the capacity to understand and make decisions. Review of Resident 3's Order Summary Report dated 9/23/25, showed a physician's order dated 6/27/25, for bilateral one-fourth bed rails in place to assist with bed mobility. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 3's Bed Rail Assessment and Consent dated 9/3/25, showed the resident had the right and left one-fourth length rails for bed mobility. Review of Resident 3's Bed Rail and Mattress Safety assessment dated [DATE], showed Zones 1 to 6 were assessed; however, further review of the assessment showed no documented evidence Zone 7 was assessed. On 9/22/25 at 0833 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 3. Resident 3 was observed lying in his bed with bilateral bed rails up. Resident 3 stated that he used the bed rails to get up in bed. 7. Medical record review for Resident 8 was initiated on 9/22/25. Resident 8 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 8's H&P examination dated 6/24/25, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's Order Summary Report dated 9/23/25, showed a physician's order dated 6/21/25, for bilateral one-fourth bed rails in place to assist with bed mobility. Review of Resident 8's Bed Rail Assessment and Consent dated 9/3/25, showed the resident had the right and left one-fourth length rails in place to assist with bed mobility and transferring assistance. Review of Resident 8's Bed Rail and Mattress Safety assessment dated [DATE], showed Zones 1 to 6 were assessed; however, further review of the assessment showed no documented evidence Zone 7 was assessed. On 9/22/25 at 1254 hours, an observation and concurrent interview for Resident 8 with LVN 7. Resident 8 was observed lying in her bed with one-fourth bilateral side rails up. LVN 7 stated Resident 8 used the side rails to turn and reposition self in bed. 8. Medical record review for Resident 10 was initiated on 9/22/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 12/4/24, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's Order Summary Report dated 9/23/25, showed a physician's order dated 6/30/21, for bilateral one-fourth bed rails in place for sense of security. Review of Resident 10's Bed Rail Assessment and Consent dated 7/24/25, showed the resident had the right and left one-fourth length rails for Resident 10 feeling of secure when she touched the bed rails. Review of Resident 10's Bed Rail and Mattress Safety assessment dated [DATE], showed Zones 1 to 6 were assessed; however, further review of the assessment showed no documented evidence Zone 7 was assessed. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/22/25 at 0924 hours, an observation and concurrent interview was conducted with Resident 10. Resident 10 was observed lying in her bed with bilateral bed rails up, and stated she felt secure having the bed rails up. 9. Medical record review for Resident 29 was initiated on 9/22/25. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's H&P examination dated 8/31/25, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's Order Summary Report dated 9/25/25 showed a physician's order dated 8/29/25, for bilateral one-fourth bed rails in place to assist with bed mobility. Review of Resident 29's Bed Rail Assessment and Consent dated 9/3/25, showed the resident had the right and left 1/4 (quarter) length rails to help assist with bed mobility. Review of Resident 29's Bed Rail and Mattress Safety Assessment, showed no documented evidence the entrapment zones were assessed. On 9/22/25 at 0944 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 29. Resident 29 was observed lying in her bed with bilateral bed rails up. Resident 29 stated that she used the bed rails to turn and reposition. 10. Medical record review for Resident 43 was initiated on 9/22/25. Resident 43 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 43's H&P examination dated 4/10/25, showed Resident 43 had no capacity to understand and make decisions. Review of Resident 43's Order Summary Report dated 9/23/25, showed a physician's order dated 4/2/24, for bilateral one-fourth bed rails in place to assist with bed mobility. Review of Resident 43's Bed Rail Assessment and Consent dated 6/26/25, showed the resident had the right and left one-fourth length rails to help assist with resident bed mobility and repositioning. Review of Resident 43's Bed Rail and Mattress Safety assessment dated [DATE], showed Zones 1 to 6 were assessed; however, further review of the assessment showed no documented evidence Zone 7 was assessed. On 9/22/25 at 0838 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 43. Resident 43 was observed lying in her bed with bilateral one-fourth bed rails up. Resident 43 stated that she used the bed rails to turn and reposition. On 9/25/25 at 0932 hours, an interview and concurrent facility document review was conducted with the Maintenance Staff. The Maintenance Staff verified that there was no documented evidence the entrapment zone was assessed for Resident 29. Review of Residents 3, 8, 10 and 43 Bed Rail and Mattress Safety Assessment Forms for entrapment, showed Zones 1, 2, 3, 4, 5 and 6 were documented, however Zone 7 was not included on the entrapment forms. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555141	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Town & Country	555 East Memory Lane Santa Ana, CA 92706

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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 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/25/25 at 1343 hours, an interview was conducted with the Administrator and DON. The Administrator and the DON were informed and acknowledged the above findings.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and facility P&P review, the facility failed to ensure the call light system (a communication system which are utilized by the residents to call for staff assistance) for two of two nurses stations (Nurse Stations A and B) were fully functional. * The facility failed to ensure the call light system panel console had an audible sound heard from Nurse Stations A and B. These failures had the potential for the residents in the facility not to receive assistance from the staff in a timely manner. Findings: Review of the facility's P&P titled Call lights revised 3/26/23, showed the purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow the residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Ensure the call systems alerts staff members directly or goes to a centralized staff work area. Staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified. 1. On 9/22/25 at 1014 hours, the call light on Room D was observed on, staff are passing by, and nobody was answering the call light. The call light system at Nursing Station B did had no audible sound while the light was on in Room D. On 9/22/25 at 1016 hours, an observation and concurrent interview for the call light system in Nurse Station B was conducted with the IP. The IP verified there should be an audible sound heard from the call light system when the call light was activated in Room D. The IP stated the night staff lowered the sound for the call light system in Nursing Station B and should have turned up the volume of the sound. On 9/25/25 at 0857 hours, an interview was conducted with the DON. The DON verified and acknowledged the above findings. The DON stated there should be an audible sound from the call light panel at the nurse's station when the call light was turned on. On 9/25/25 at 1343 hours, an interview was conducted with the Administrator and DON. The Administrator and DON were informed and acknowledged the above findings. 2. On 9/22/25 at 0937 hours, a red light was flashing from the door of Room A. There was no audible sound heard from Nurse Station A. On 9/22/25 at 0939 hours, a red light was flashing from the door of Room B. There was no audible sound heard from Nurse Station A. On 9/22/25 at 0926 hours, a white light was flashing from the door of Room C. There was no audible sound heard from Nurse Station A. The staff were observed passing by but did not answer the call light. The staff were also observed in Nurse Station A but did not answer the call light. (continued on next page)

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/22/25 at 1009 hours, an observation of the nurse call system console and concurrent interview was conducted with the Unit Secretary. When asked about the nurse call system console, the Unit Secretary stated the nurse call system console located in Nurse Station A alerted the regular call lights and the emergency call lights from all the SNF rooms from Nurse Stations A and B in the facility, although Nurse Station B also has its own nurse call system console. The Unit Secretary stated a regular call light would have a soft beep, while an emergency call light from the bathroom or shower rooms would have a loud honking sound. The nurse call system console was observed showing rooms on the display panel but only a faint beep was heard from the console. The Unit Secretary was observed adjusting the volume on the panel, then a louder beep was heard from the console. The Unit Secretary verified there was a faint beep from the console before she adjusted the volume and stated, it was quieter earlier. The Unit Secretary stated she was not sure who adjusted the volume down. On 9/24/25 at 0624 hours, an interview was conducted with CNA 4. When asked about the call light sound, CNA 4 stated there were times during her shift were all the CNAs were busy assisting the residents and all the nurses were passing the medications to the residents, and the call light sound was helpful to let the staff know when another call light was on if the light was not visible, such as when the CNAs were inside the room assisting another resident. CNA 4 stated when she heard the call light sound, she would peek, when possible, from the room of the resident she was currently assisting to see what room had the call light on. CNA 4 stated whoever was available should answer the call light. On 9/25/25 at 1350 hours, an interview was conducted with the Director of Facilities. The Director of Facilities stated the maintenance department was not responsible for the routine inspection or maintenance of the facility's call light system, but only for repairs when requested. On 9/25/25 at 1358 hours, an observation of the nursing call light system console, and concurrent interview was conducted with the IP. The nursing call light system console for Nurse Station A was observed with more audible sound than the console in Nurse Station B. After a few minutes, LVN 11 was able to adjust the volume of the nursing call light system console in Nursing Station B. The IP stated the facility did not have a routine inspection or maintenance of the nursing call light system, but they could request the maintenance department to call an outside vendor for repairs. When asked about the nursing call light system, the IP stated when the nursing call light system was installed, they were told they could talk to the residents from the machine, but they were never told to play with it' or adjust the volume.