STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555718	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 accommodation of needs for one final sampled resident (Resident 43) reviewed for accommodation of needs. *The facility failed to ensure Resident 43's bed controller (used to reposition the bed) was within reach. This failure placed the resident at risk for not having her needs met.Findings: Review of the facility's P&P titled Accommodation of needs revised 3/2021 showed the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. The resident's individual needs and preferences are accommodated to the extend possible, except when the health and safety of the individual or other residents would be endangered. Medical record review for Resident 43 was initiated on 12/8/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's Care Plan Report showed a care plan initiated 11/12/25, for risk for pain and discomfort related to cerebral edema and left-sided weakness. On 12/8/25 at 0806 hours, an observation and concurrent interview was conducted with Resident 43. Resident 43 was in her room without staff present. Resident 43 was lying in her bed and stated she was uncomfortable. Resident 43 was asked where the controller used to reposition her bed was located, to which she replied, I do not see the controller. Resident 43's bed controller was observed wrapped around Resident 43's television out of Resident 43's sight and reach. Resident 43 stated she repositioned herself frequently related to pain. On 12/8/25 at 0807 hours, an observation and concurrent interview was conducted with CNA 3. CNA 3 was in the hallway. CNA 3 was assigned to provide care for Resident 43. CNA 3 stated Resident 43 had left sided weakness and required total care from the staff. CNA 3 stated she was assisting Resident 43 with breakfast, however, CNA 3 had to leave Resident 43's room. CNA 3 verified Resident 43's bed repositioning controller was wrapped around Resident 43's television, out of Resident 43's sight and reach. CNA 3 stated before she left Resident 43's room she should have placed the bed controller within reach of Resident 43. CNA 3 stated Resident 43 repositioned herself in bed due to episodes of pain.

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 two of five final sampled residents (Residents 7 and 36) reviewed for unnecessary medications were free from unnecessary psychotropic medications. * The facility failed to ensure the monitoring for Resident 7's behavior for the use of the divalproex (anticonvulsant medication used to manage bipolar disorder) and escitalopram (antidepressant) medications were specific. * The facility failed to ensure the monitoring for Resident 36's behavior for the use of aripiprazole (antipsychotic medication) was specific and consistent to the resident's diagnosis. This failure had the potential for Residents 7 and 36 to experience potential harm from adverse consequences and a significant decline in functioning. Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 2/2025 showed psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: a. determining adequate indications for use; b. establishing appropriate dose (including duplicate therapy) and duration; c. adequate monitoring for efficacy and adverse consequences; d. determining appropriateness of gradual dose reduction; and e. preventing, identifying, and responding to adverse consequences. Behavioral and other non-pharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medication, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefiting the resident, to find an optimal dose, or in an effort to discontinue the medication. 1. Medical record review for Resident 7 was initiated on 12/8/25. Resident 7 was admitted to the facility on [DATE] and readmitted on [DATE]. Review of Resident 7's H&P examination dated 8/22/25, showed Resident 7 had no capacity to understand and make decisions. a. Review of Resident 7's Order Summary Report dated 12/9/25, showed the following physician's orders: - dated 8/21/25, to administer divalproex sodium delayed release 125 mg, one capsule via GT two times a day for dementia with behavior disturbance manifested by mood lability; and - dated 10/30/25, for the use of the Depakote (brand name for divalproex), to monitor for dementia with behavioral disturbance manifested by mood lability; to tally every shift. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 7's MAR for December 2025 showed Resident 7 was administered the divalproex 125 mg, one capsule via GT two times a day, from 12/1 to 12/8/25 at 0900 and 1700 hours. Further review of Resident 7's MAR showed for the monitoring of the episodes of dementia with behavioral disturbance manifested by mood lability, the licensed nurses' documented the following: - on 12/1/25, one episode during the day, evening and night shifts; - on 12/2/25, one episode during the day and evening shifts; - on 12/3/25, one episode during the day shift, and two episodes during the evening shift; - on 12/4/25, two episodes during the evening shift; - on 12/5/25, one episode during the night shift; - on 12/6/25, two episodes during the day and evening shift; - on 12/7/25, two episodes during the day and one episode during the evening and night shifts; and - on 12/8/25, one episode during the day and evening shifts. b. Review of Resident 7's Order Summary Report dated 12/9/25, showed the following physician's orders: - dated 8/21/25, to administer escitalopram 10 mg, give one tablet via GT one time day for depression manifested by sad affect; and - dated 8/22/25, for the use of the escitalopram, to monitor the episodes of depression manifested by sad affect and tally every shift. Review of Resident 7's MAR for December 2025 showed Resident 7 was administered the escitalopram medication 10 mg one tablet via GT daily for depression from 12/1 to 12/9/25 at 0900 hours . Further review of Resident 7's MAR showed for the monitoring of the episodes of depression manifested by sad affect, the licensed nurses' documented the following: - on 12/1/25, one episode during the day and evening shifts; and - on 12/8/25, one episode during the day and evening shifts. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/25 at 1143 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 1. LVN 1 stated Resident 7 was administered the divalproex medication for behavioral disturbance manifested by mood lability and was administered the escitalopram medication for depression manifested by sad affect. When asked about the monitoring of Resident 7's manifested behaviors, LVN 1 stated for mood lability, she monitored Resident 7 for changes in her mood, for when Resident 7's mood changed from calm to excitement. For the monitoring of Resident 7's depression manifested by sad affect, LVN 1 stated Resident 7 was unable to verbalize her sadness. When asked how LVN 1 monitored for the behavior, LVN 1 stated she monitored for when Resident 7 slept more or was not observed smiling. LVN 1 agreed the monitored behaviors were not specific. LVN 1 stated if the monitored behaviors were not specific, then the episodes of behaviors being monitored would not be accurate and may affect the potential gradual dose reductions or the determination of whether the medication was effective or not. On 12/11/25 at 1343 hours, an interview and concurrent medical record review for Resident 7 was conducted with the ADON. The ADON stated the licensed nurses were responsible for the monitoring of the manifested behaviors related to the use of the psychotropic medications. The ADON reviewed Resident 7's medical record and stated the monitored behavior manifestations were not specific. The ADON agreed mood lability was subjective to the evaluator and not taking into consideration the resident's baseline mood. Additionally, the ADON agreed the monitoring of sad affect was not specific and did not indicate the specific sad behavior to monitor for Resident 7. The ADON was informed and acknowledged the above findings. 2. According to clevelandclinic.org, depression is a common mental health condition which includes depressive symptoms of feeling sad or hopeless. The condition can also cause difficulty with thinking, memory, eating and sleeping. Mood swings are sudden changes in how a person feels at a particular time. Medical record review for Resident 36 was initiated on 12/8/25. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 1/7/25, showed the resident had the capacity to understand and make decisions. Review of Resident 36's Order Summary Report dated 12/11/25, showed the following physician's orders: - dated 1/1/25, to monitor depression m/b mood swings from being pleasant to suddenly being distress every shift. Tally by hashmarks every shift for the use of Abilify (antipsychotic medication); and - dated 10/1/25, for aripiprazole (antipsychotic medication) oral tablet 2 mg give 0.5 tablet by mouth one time a day for depression manifested by mood swings from being pleasant to suddenly being distressed (adjunct treatment to the use of sertraline (antidepressant medication)). Review of Resident 36's Psychoactive Behavior Summary form dated January through October 2025 showed the diagnosis and behavior for the use of aripiprazole was for depression manifested by mood swings from being pleasant and suddenly being distressed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/25 at 1200 hours, an interview and concurrent medical record review for Resident 36 was conducted with LVN 7. LVN 7 stated for psychotropic medications, she observed for the side effects, the behavior, or reason why the resident was on psychotropic medications. LVN 7 reviewed the behavior monitoring ordered for Resident 36 for the aripiprazole medication and verified the behavior monitoring was for depression manifested by mood swings from being pleasant to suddenly being distressed every shift. When asked if depression was the same as mood swings, LVN 7 stated no. When asked for the facility's process when the diagnosis and behavior manifestations did not match, LVN 7 stated she would notify the supervisor and the physician. On 12/11/25 at 1343 hours, an interview and concurrent medical record review for Resident 36 was conducted with the ADON. The ADON verified the diagnosis of depression and the behavior manifestations of mood swings for the use of aripiprazole were not the same and needed to be clarified with the physician. On 12/11/25 at 1550 hours, an interview was conducted with the Administrator, DON, and ADON. The Administrator, DON, and ADON were informed and acknowledged the 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plan was implemented for one of 13 final sampled residents (Resident 2). * The facility failed to implement the care plan for the safe storage of Resident 2's nasal cannula. Resident 2's nasal cannula was observed lying directly on top of the oxygen concentrator. This failure posed the risk for Resident 2's nasal cannula to become contaminated with pathogens, which posed the risk for infection. Findings: Medical record review for Resident 2 was initiated on 12/8/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. On 12/8/25 at 0847 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed in her room. An oxygen concentrator was observed adjacent to Resident 2's bed. A nasal cannula was observed attached to the oxygen concentrator. The nasal cannula was observed lying directly on top of the oxygen concentrator. Resident 2 stated she utilized oxygen to assist her with her breathing. Resident 2 stated she last utilized oxygen this morning. Review of Resident 2's Care Plan Report showed a problem titled At Risk for Shortness of Breath or Respiratory Distress related to COPD revised on 11/20/25. The care plan tasks included to monitor the oxygen tubing and nasal cannula with proper storage at the bedside, initiated 11/10/25. On 12/8/25 at 0851 hours, an observation, interview, and concurrent medical record review was conducted with LVN 5. LVN 5 stated at the beginning of the shift, Resident 2 received continuous oxygen at a rate of 2 liters per minute via nasal cannula. LVN 5 stated Resident 2 removed her oxygen this morning in order to eat breakfast. LVN 5 verified Resident 2's nasal cannula was observed lying directly on top of the oxygen concentrator. LVN 5 stated Resident 2's nasal cannula should have been stored in a clean plastic bag for infection control, in accordance with Resident 2's care plan problem titled At Risk for Shortness of Breath or Respiratory Distress related to COPD revised on 11/20/25.

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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 and medical record review, the facility failed to ensure the plan of care for one of 13 final sampled residents (Resident 36) was revised to address the resident's specific care needs. * Resident 36's care plan addressing the episodes of bladder and bowel incontinence was not revised when the resident was determined as not a candidate for B&B (bowel and bladder) retraining or toileting program. This failure posed the risks for the resident to not receive the care and services required to attain or maintain the highest level of physical and mental well-being. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person-Centered revised 3/2022 showed assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. On 12/8/25 at 0901 hours, during the initial tour of the facility, Resident 36 was observed with PureWick external catheter (a non-invasive device for managing urinary incontinence) connected to a clear canister to drain urine. Resident 36 stated she has been using the external catheter since she was admitted to the facility. Medical record review for Resident 36 was initiated on 12/8/25. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 1/7/25 showed the resident had the capacity to understand and make decisions. Review of Resident 36's Order Summary Report showed a physician's order dated 1/1/25 for PureWick catheter attached to canister-may drain every shift and as needed when resident is in bed every shift and as needed. Review of Resident 36's Plan of Care dated 1/1/25, showed a care plan problem for episodes of bladder and bowel incontinence due to impaired mobility, dependence on staff for toileting needs, with long term history of bladder and bowel incontinence. Resident uses PureWick external catheter for bladder function and incontinence prior to the admission to the facility. The care plan interventions included to assess if the resident was appropriate for B&B retraining program or B&B toileting program. Resident 36's medical record failed to show the resident was assessed if appropriate for B&B retraining program or B&B toileting program. On 12/11/25 at 0920 hours, an interview and concurrent medical record review for Resident 36 was conducted with MDS Coordinator 1. MDS Coordinator 1 verified the interventions in the care plan to assess the resident if appropriate for B&B retraining program or B&B toileting program. When asked if she conducted an assessment for Resident 36, MDS Coordinator 1 stated she talked to Resident 36 and the resident informed MDS Coordinator 1 that she has been using PureWick for a long time at home. MDS Coordinator 1 stated Resident 36 was not a candidate for B&B retraining or toileting program. MDS Coordinator 1 also verified Resident 36's medical record did not have documentation an assessment was conducted to determine if the resident was appropriate for B&B retraining program or toileting program. In addition, MDS Coordinator 1 verified the care plan should have been revised to remove the intervention to assess if the resident was appropriate for B&B retraining program or toileting program since Resident 36 was not a candidate for retraining. On 12/11/25 at 1550 hours, an interview was conducted with the Administrator, DON, and ADON. The Administrator, DON, and ADON were informed of the findings and acknowledged the 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 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. (continued on next page)

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F 0684 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 quality care and services were provided for one of three residents (Resident 51) reviewed for closed records. * The facility failed to ensure Resident 51 was administered the budesonide (steroid medication) medication as per the physician's orders and failed to notify the physician when the medication was not available for administration to Resident 51. Resident 51 was transferred to the acute care hospital. These failures had the potential for Resident 51 to not receive the necessary care and services to maintain the highest physical well-being. Findings: Review of the facility's P&P titled Administering Medications revised 4/2019 showed the medications were administered in accordance with prescriber orders, including any required time frame. Review of the facility's P&P titled Ordering and Receiving Medications from Alliance Pharmacy, Inc dated 1/2025 showed new medications, except for emergency or stat medications, were ordered as follows:1. If needed before the next regular delivery, the facility shall phone the medication order to the pharmacy immediately upon receipt; to inform the pharmacy of the need for prompt delivery and request the delivery within four hours. Closed medical record review for Resident 51 was initiated on 12/11/25. Resident 51 was admitted to the facility on [DATE], readmitted on [DATE], and discharged on 10/6/25. Resident 51 had the diagnosis of pneumonia (a lung infection caused by bacteria, viruses, or fungi, leading to inflamed air sacs (alveoli) that fill with fluid or pus, causing cough, fever, chills, and difficulty breathing) and acute respiratory failure with hypoxia (a critical condition where the lungs can't get enough oxygen into the blood). Review of Resident 51's Admit/Readmit Screener dated 10/5/25, showed the licensed nurse's documentation Resident 51 was admitted to the facility from the acute care hospital at 1825 hours and Resident 51 was on continuous oxygen via the nasal canula. Review of Resident 51's Order Summary Report showed a physician's order dated 10/5/25, to administer budesonide inhalation 0.5 mg/2 ml, give two milliliters inhalation orally via the nebulizer (a medical device that turns liquid medicine into a fine, inhalable mist, delivering it directly to the lungs) every 12 hours for respiratory failure. Review of Resident 51's MAR for October 2025 showed on 10/5/25 at 2100 hours, the licensed nurse documented 9. Further review of the MAR showed 9= Other/see progress notes. Review of Resident 51's Progress Notes showed the following licensed nurses' entries:- dated on 10/5/25 at 2028 hours, for the administration of the budesonide inhalation suspension 0.5 mg/2 ml, the licensed nursed documented awaiting delivery from pharmacy.- dated on 10/6/25 at 0652 hours, the licensed nurse documented Resident 51 was saturating at 92% with 4 liters per minute via the nasal canula (a flexible tube to deliver oxygen into the nose). The resident stated she was feeling anxious which was causing her to hyperventilate. The resident was requesting for something for her anxiety. The physician was made aware of the resident and family member's request. - dated 10/6/25 at 1024 hours, the licensed nurse documented Resident 51 was noted with respiratory distress and sent to the hospital via 911 emergency department at approximately 0900 hours. Resident 51 was noted with shortness of breath and crackles upon auscultation. Further review of Resident 51's Progress Notes failed to show the documentation the budesonide medication was administered to Resident 51 on 10/5/25 and failed to show the documentation the physician was informed of the missed dose. On 12/11/25 at 1025 hours, an interview and concurrent medical record review for Resident 51 was conducted with the ADON. The ADON stated for the newly admitted residents, the routine medications should be available from the pharmacy within four hours of admission. The ADON stated if the medication was not available at the time of the scheduled administration, the physician should be informed and made aware. The ADON further stated the licensed nurse should inform the physician, obtain any orders, and document in the progress notes. The ADON reviewed Resident 51's medical record and verified the above findings. The ADON stated Resident 51 was prescribed the budesonide medication for every 12 hours for respiratory failure and the nebulizer treatment should have been administered on 10/5/25 at 2100 hours. The ADON verified there were no documentation the budesonide medication was administered on 10/5/25 and stated there was no documentation the physician was informed when the prescribed medication was not available and was not administered to Resident 51. The ADON was informed and acknowledged the above findings.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the treatment was provided as per the physician's order to prevent a decline in ROM (range of motion) functions for one of two final sampled residents (Resident 41) reviewed for range of motion. * The facility failed to follow a physician's order to apply the PRAFO boot (a specialized medical brace that stabilizes the ankle and foot, primarily to prevent and treat heel skin breakdown (ulcers) by keeping the heel elevated and offloaded, while also managing conditions like foot drop, contractures, and neurological deficits) to Resident 41's left foot when in bed. This failure had the potential for Resident 41 to sustain a decline in ROM functions. Findings: Review of the facility's P&P titled Restorative Nursing Services revised 7/2027 showed restorative goals and objectives are individualized and resident-centered, and are outlined in the resident's plan of care. On 12/8/25 at 0853 hours, during the initial tour of the facility, Resident 41 was observed in bed and the hand splints and PRAFO brace were observed on top of the bedside drawer. Medical record review for Resident 41 was initiated on 12/8/25. Resident 41 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of the facility document showed a physician's order dated 6/22/22, for the RNA to apply the left PRAFO boot when in bed for positioning and to prevent contractures. Review of Resident 41's Order Summary Report showed a physician's order dated 12/31/22, for the RNA to apply the left-hand splint daily for four hours as tolerated. Review of Resident 41's plan of care showed a care plan problem dated 6/22/22, addressing Resident 41's risk for further decline in mobility and contractures. The interventions included for the RNA to apply the left PRAFO boot when Resident 41 was in bed for positioning and to prevent contractures, and for the RNA to apply the left-hand splint for four hours daily, as tolerated. Review of Resident 41's H&P examination dated 7/31/25, showed Resident 41 had the capacity to understand and make decisions, and had a history of multiple cerebral vascular accidents (stroke) with left sided hemiparesis (one-sided muscle weakness, affecting the arm, leg, and sometimes the face, resulting from a central nervous system injury, most commonly a stroke or traumatic brain injury). Review of Resident 41's MDS assessment dated [DATE], showed Resident 41 was cognitive intact and Resident 41 had an impairment on one side for the upper and lower extremities functional limitation in range of motion. On 12/9/25 at 1445 hours, an observation and concurrent interview was conducted with Resident 41. Resident 41 was observed lying in bed. Resident 41 stated his left foot boot was not on and was usually applied for four hours for the same duration as the left-hand splint. Resident 41's hand splint and PRAFO boot were observed in the drawer. Review of Resident 41's Restorative Nursing Weekly Summary dated 12/5/25, showed the documentation the splint was applied to Resident 41's left hand and leg for four to six hours during the AM shift. Under the comment line showed the documentation resident refused left. No other documentation to show what days during that week Resident 41 refused, and which splint Resident 41 refused to apply. On 12/10/25 at 1417 hours, Resident 41 was observed lying in bed. Resident 41 was not observed wearing the PRAFO boot on the left foot. On 12/10/25 at 1421 hours, an interview was conducted with CNA 1. CNA 1 stated the RNA was previously in Resident 41's room and had removed Resident 41's left foot and arm splints. On 12/10/25 at 1435 hours, an interview and concurrent medical record review for Resident 41 was conducted with RNA 1. RNA 1 stated Resident 41 had a history of a stroke and had left-sided weakness. RNA 1 stated she was responsible for applying the hand splint to Resident 41's left hand and the PRAFO boot to Resident 41's left foot. RNA 1 stated she applied the hand splint and the PRAFO Resident 41's left hand and left foot for four to six hours daily and removed the splint and PRAFO boot at the same time. When asked about the physician's order for the duration of the device applications, RNA 1 reviewed the physician's order and verified the physician's order for the left-hand splint was for four hours daily, and the PRAFO boot was ordered for when Resident 41 was in bed. On 12/11/25 at 1035 hours, an interview and concurrent medical record review for Resident 41 was conducted with the ADON. The ADON stated the PRAFO boots were used to prevent foot contractures and was applied as per the physician's order. The ADON reviewed Resident 41's medical records and stated Resident 41 had a physician's order for the application of the left PRAFO boot when in bed. The ADON reviewed the RNA documentation and stated the PRAFO boot and hand splint were applied daily for four to six hours, by the RNA. The ADON verified the above findings. The ADON was informed and acknowledged the above findings.

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	555718	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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 one of one final sampled resident (Resident 26) reviewed for falls were provided the necessary services after a fall. * The facility failed to ensure Resident 26's fall risk evaluation was completed accurately after Resident 26 had a fall on 11/19/25, and failed to monitor Resident 26 for episodes of getting out of bed, as per the care plan. These failures had the potential risk of inaccurate fall risk score, the failure to implement the appropriate fall risk interventions, and risk of injury for Resident 26.Findings: Review of the facility's P&P titled Falls- Clinical Protocol revised 3/2018 showed based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address the risks of clinically significant consequences of falling. The staff and physician will monitor and document the individual's response to interventions intended to reduce falling or the consequences of falling. Medical record review for Resident 26 was initiated on 12/8/25. Resident 26 was admitted to the facility on [DATE], with the diagnosis of history of falling. Review of Resident 26's plan of care showed a care plan problem dated 8/26/23, addressing Resident 26's risk for fall and injury. The care plan showed the documentation, on 9/25/24 Resident 26 was found sitting on the floor, on 10/21/24 Resident 26 was found sitting on the floor with episodes of trying to reach for personal items in the dresser without asking for assistance. The interventions showed to monitor Resident 26 for episodes of trying to get out of the bed unassisted. Review of Resident 26's medical record showed the licensed nurses' documentation for the following einteract Change in Condition Evaluations:- dated 3/31/25, Resident 26 was found sitting on the floor next to his wheelchair. Resident stated he slid off the wheelchair.- dated 6/9/25, Resident 26 was seen sitting on the floor and the call light was within reach and was not activated.- dated 11/19/25, the charge nurse entered the room to see Resident 26 sitting on the floor with the wheelchair behind him. Review of the evaluation showed Resident 26's most recent vital signs and pain assessment were not entered on the evaluation and the evaluation was not signed by the licensed nurse. Review of Resident 26's Order Summary Report showed a physician's order dated 8/30/25, to administer mirtazapine (antidepressant) 7.5 mg one tablet by mouth at bedtime for depression manifested by poor meal intake less than 50% of meals. Review of Resident 26's H&P examination dated 9/20/25, showed Resident 26 had the capacity to understand and make decisions. Review of Resident 26's MDS assessment dated [DATE], showed Resident 26 was cognitively intact and required partial/moderate assistance where the helper did less than half the effort for the following mobility: sit to lying on the side of the bed, sit to standing, and chair/bed-to-chair transfer. Review of Resident 26's Fall Risk Evaluation dated 11/19/25, showed the licensed nurse's documentation Resident 26 had no falls in the past three months (however, Resident 26 had a fall on 11/19/25) and Resident 26 was not administered any of the listed medications (or medication classes) currently or within the last seven days (however, Resident 26 was taking the antidepressant psychotropic medication routinely). Further review of Resident 26's medical records failed to show the documentation of the monitoring of Resident 26 for trying to get out of the bed unassisted. On 12/9/25 at 1408 hours, an interview and concurrent medical record review for Resident 26 was conducted with LVN 1. LVN 1 stated a fall risk evaluation was done after a resident had a fall to evaluate for any recent changes in condition, any changes in medication, or continence level, and to determine if there was a change in the fall risk score. LVN 1 stated the fall interventions implemented would be initiated depending on the fall risk score. LVN 1 stated Resident 26 was alert and had incidences where he attempted to transfer out of the bed or the chair by himself. LVN 1 stated Resident 26 had a fall during LVN 1's shift, on 11/19/25 and LVN 1 had initiated the Change in Condition Evaluation for Resident 26. LVN 1 reviewed Resident 26's medical record and verified the above findings. LVN 1 stated the fall risk evaluation should be accurate. On 12/9/25 at 1530 hours, an interview and concurrent medical record review for Resident 26 was conducted with the ADON. The ADON stated for any unwitnessed fall, the facility would initiate a head-to- toe assessment, documented in the Change of Condition Evaluation. The ADON stated the evaluation should be accurate and completed by the end of the shift. The ADON reviewed Resident 26's medical record and verified the above findings. On 12/11/25 at 1153 hours, a follow-up interview and concurrent medical record review for Resident 26 was conducted with the ADON. The ADON stated Resident 26 had a history of falls in the facility. The ADON reviewed Resident 26's care plan addressing the risk for fall and injury. The ADON was asked to show the documentation of the monitoring of Resident 26 for getting out of bed unassisted. The

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility to provide the necessary respiratory care for two of two final residents reviewed for respiratory care (Residents 2 and 22). * The facility failed to obtain a physician's order for the administration of oxygen and failed to ensure the nasal cannula was stored in a sanitary condition, for Resident 2. * The facility failed to ensure Resident 22's nasal cannula was stored in a sanitary condition. These failures posed the risk for the residents' oxygen equipment to become contaminated with pathogens and had the potential to negatively impact the residents' medical condition.Findings: Review of the facility's P&P titled Oxygen Administration revised 10/2010 showed the purpose of this procedure is to provide guideline for safe oxygen administration. Verify that there is a physician's order for this procedure. 1. Medical record review for Resident 2 was initiated on 12/8/25. Resident 2 was admitted to the facility on [DATE], and readmitted on [DATE]. On 12/8/25 at 0847 hours, an observation and concurrent interview was conducted with Resident 2. Resident 2 was observed in her room. An oxygen concentrator was observed adjacent to Resident 2's bed. A nasal cannula was observed attached to the oxygen concentrator. The nasal cannula was observed lying directly on top of the oxygen concentrator. Resident 2 stated she utilized oxygen to assist her with her breathing. Resident 2 stated she last utilized oxygen this morning. Review of Resident 2's medical record failed to show an active order for the administration of continuous oxygen via nasal cannula. On 12/8/25 at 0851 hours, an observation, interview, and concurrent medical record review was conducted with LVN 5. LVN 5 stated at the beginning of the shift, Resident 2 had received continuous oxygen at a rate of 2 liters per minute, via nasal cannula. LVN 5 stated Resident 2 removed her oxygen this morning in order to eat breakfast. LVN 5 verified Resident 2's nasal cannula was observed lying directly on top of the oxygen concentrator. LVN 5 stated Resident 2's nasal cannula should have been stored in a clean plastic bag for infection control. LVN 5 then reviewed Resident 2's current orders and verified Resident 2 did not have an order for the use of continuous oxygen at a rate of 2 liters per minute, via nasal cannula. LVN 5 stated a physician's order was required for the use of continuous oxygen. 2. Medical record review for Resident 22 was initiated on 12/8/25. Resident 22 was admitted to the facility on [DATE]. Review of Resident 22's Order Summary Report showed an order dated 11/12/25, for the administration of continuous oxygen at a rate of 2 liters per minute via nasal cannula, for shortness of breath to maintain an oxygen level of greater than 92%. On 12/8/25 at 0750 hours, an observation and concurrent interview was conducted with Resident 22. Resident 22 was observed in her room. A nasal cannula attached to oxygen tubing was observed lying directly on top of Resident 22's wheelchair. Resident 22 stated when she utilized her wheelchair, she had a portable oxygen tank which attached to her wheelchair, at which time she would use the nasal cannula. Resident 22 stated she last used the nasal cannula on Saturday. On 12/8/25 at 0755 hours, an observation and concurrent interview was conducted with LVN 5. LVN 5 verified Resident 22's nasal cannula was lying directly on top of Resident 22's wheelchair. LVN 5 stated the nasal cannula should be stored in a clean plastic bag for infection control. Cross reference F656

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 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 provide the appropriate pain management for two of two final sampled residents (Residents 5 and 10) reviewed for pain management. * The facility failed to ensure Resident 5 received the appropriate intervention for pain, when a pain level of 5 (on the pain scale of 0 to 10 with 0 = no pain and 10 = worst) was reported and stronger pain medication meant for severe pain level of 7-10 was administered to the resident. * The facility failed to ensure the NPI (nonpharmacological intervention) was provided and documented prior to Resident 10 receiving a pain medication. These failures had the potential to put Residents 5 and 10 at risk for ineffective pain management and adverse effects related to the use of unnecessary pain medications. Findings: Review of the facility's P&P titled Administering Pain Medications revised 4/2025 showed the pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on the professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. Steps 5 in the procedure is evaluated and document effectiveness of non-pharmacological interventions (e.g. repositioning, warm or cold compress, etc.). 1. Medical record review for Resident 5 was initiated on 12/11/25. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Order Summary Report showed an order dated 11/10/25, to administer morphine sulfate (narcotic pain medication) solution 20 mg/ml, give 0.5 ml by mouth every two hours a needed for severe pain for pain level of 7-10. Review of Resident 5's H&P examination dated 11/11/25, showed Resident 5 did not have the capacity to understand and make decisions. Review of Resident 5's MAR for December 2025 showed on 12/9/25 at 0924 hours, Resident 5 was administered morphine sulfate 0.5 ml by mouth for a pain level of 5. On 12/11/25 at 1018 hours, an interview and concurrent medical record review for Resident 5 was conducted with LVN 3. LVN 3 stated for the residents who reported pain, the licensed nurse would assess the resident pain level prior to the administration of the pain medications. LVN 3 further stated, then the pain medication would be administered as per the physician's order and within the ordered parameters. LVN 3 stated for the pain level of 5, the licensed nurse should not have given morphine sulfate medication because the pain parameter for the morphine medication was for pain level of 7-10. LVN 3 reviewed Resident 5's medical record and verified the above findings. On 12/11/25 at 1537 hours, an interview was conducted with the ADON. The ADON stated she expected the licensed nurses to accurately document the resident's pain level and give pain medication as the physician ordered. The ADON was informed and acknowledged above findings. 2. Medical record review for Resident 10 was initiated on 12/10/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 3/25/25, showed Resident 10 did not have the capacity to understand and make decisions. Review of Resident 10's Order Summary Report showed an order dated 7/16/25, to administer acetaminophen (pain medication) 50 mg oral tablet, give two tablets by mouth every six eight hours for left knee pain. Review of Resident 10's MAR for December 2025 failed to show documented evidence NPI were provided to the resident prior to giving the acetaminophen medication. On 12/10/25 at 1457 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 1. LVN 1 stated prior to the administration of the pain medication, the licensed nurse was expected to assess the resident's level of pain, implement and document the NPI implemented. LVN 1 reviewed Resident 10's MAR and stated she had provided NPI to the resident, but did not document it was provided. LVN 1 verified there was no documented evidence of NPI was provided prior to administering the acetaminophen medication in Resident 10's medical record. On 12/10/25 at 1458 hours, an interview was conducted with the ADON. The ADON stated when the residents reported pain, the licensed nurses were expected to implement and document the NPI and the effectiveness. The ADON stated if the NPI was not effective, the licensed nurses should administer pain medication. The ADON stated the NPI should be implemented prior to administering the pain medication to reduce the unnecessary use of pharmacological drugs. The ADON stated if the NPI were effective, then the pharmacological drugs would not be needed. The ADON was informed and verified the above findings.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview, facility P&P review, and facility document review, the facility failed to ensure the licensed nurses had specific competencies and skill sets needed to care for the residents. * The facility failed to conduct the staff competency check for the use of PureWick external catheter (a non-invasive device for managing urinary incontinence). This failure placed the residents at risk for unsafe practices and adverse outcomes. Findings: Review of the facility's P&P titled Staffing, Sufficient and Competent Nursing dated 10/24/24, showed Competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. Licensed staff must demonstrate the skills and techniques necessary to care for resident needs including, but not limited to the following areas: nursing skills consistent with scope of practice. Review of the facility's P&P titled PUREWICK dated 2/2024 showed the licensed nurse will assess skin for compromise and perform perineal care prior to placement of a new PureWick Female External Catheter. Review of the facility's Inservice Attendance sheets dated 11/22, 11/24, and 11/26/24, showed in-services were provided to 13 licensed nurses (RNs and LVNs) about PUREWICK. The in-service showed topics of Setting up the PureWick System, Placing the PureWick Female External Catheter, Removing the PureWick Female External Catheter, Cleaning the Collection Canister, Cleaning the Collector and Pump Tubing, and Tips and Troubleshooting. Review of the facility's form titled 2025 Skills Competency Test Checklist showed PureWick Demo cleaning demo with sections for completion date and instructor's signature. Review of LVN 6's 2025 Skills Competency Test Checklist dated 8/19/25, showed LVN 6 completed the PureWick Demo cleaning demo on 8/19/25. Review of the facility's in-service dated 9/12/25, showed an in-service was provided by the IP to 13 CNAs about PureWick System Cleaning. On 12/11/25 at 0743 hours, an interview and concurrent facility document review was conducted with LVN 6. LVN 6 verified Resident 36 had a PureWick external catheter for incontinence care. When asked if he received training regarding the use of PureWick external catheter, LVN 6 stated he received the training from the IP when Resident 36 was admitted to the facility. The training included sanitizing and cleaning, and the application of the PureWick external catheter. Review of the in-services for 11/2024 did not show LVN 6 attended the in-service about Pure Wick. LVN 6 stated the IP came in one night to do the in-service to the night shift and he signed the attendance sheet. On 12/11/25 at 0820 hours, the DON provided an in-service sign-in sheet dated 9/9/25, titled PureWick System Cleaning, and LVN 6's name was noted on the attendance sheet. However, there was no information regarding the application of the PureWick external catheter. LVN 6 stated the IP showed him how to apply. On 12/11/25 at 0841 hours, an interview and concurrent facility document review was conducted with the IP. The IP provided LVN 6's Annual Competency Checklist dated 8/19/25. The competency checklist showed the PureWick demo cleaning was completed on 8/19/25. The IP stated LVN 6 watched the video in the DSD office. When asked how the facility verified the staff's competency, the IP stated she did not assess for the staff's competency on the day LVN 6 was signed off as completed on 8/19/25. The IP verified LVN 6 only watched the video about PureWick, but the observation of LVN 6's performance about the application of PureWick external catheter was done on a different day. However, the IP verified she did not have a record of when she conducted the observation to assess for staff's competency. On 12/11/25 at 1550 hours, an interview was conducted with the Administrator, DON, and ADON. The Administrator, DON, and ADON were informed of the findings and acknowledged the findings.

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **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 NPI (nonpharmacological intervention) was implemented for three of five final sampled residents (Residents 7, 10, and 36) reviewed for unnecessary medications. * The facility failed to ensure the licensed nurses implemented the NPI and documented its effectiveness for Resident 7's observed behaviors related to the use of the divalproex (anticonvulsant medication) and escitalopram (antidepressant) medications. * The facility failed to show documentation for NPI for Resident 10's use of the Depakote (medication for mood stabilizer), quetiapine (medication to control aggressive behavior), bupropion (antidepressant medication), and buspirone (antianxiety medication). * The facility failed to ensure the licensed nurses implemented the NPI for Resident 36 who was receiving the aripiprazole (antipsychotic medication) and sertraline (antidepressant medication.) These failures had the potential to place Residents 7, 10, and 36 at risk for overuse of the medications and increased risk of experiencing adverse effects.Findings: Review of the facility's P&P titled Psychotropic Medication Use revised 2/2025 showed the psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: a. determining adequate indications for use; b. establishing appropriate dose (including duplicate therapy) and duration; c. adequate monitoring for efficacy and adverse consequences; d. determining appropriateness of gradual dose reduction; and e. preventing, identifying, and responding to adverse consequences. Behavioral and other nonpharmacological approaches are used (unless contraindicated) to minimize or eradicate the need for medication, permit the lowest possible dose if indicated, and support efforts at gradual dose reduction. The residents on the psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefiting the resident, to find an optimal dose, or in an effort to discontinue the medication. 1. Medical record review for Resident 7 was initiated on 12/8/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 7 had diagnoses including Alzheimer's disease, dementia with other behavioral disturbance, psychosis, depression, and anxiety disorder. Review of Resident 7's H&P examination dated 8/22/25, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Order Summary Report dated 12/9/25, showed the following physician's orders: * For the use of the divalproex medication: (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 8/21/25, to administer divalproex sodium delayed release 125 mg, one capsule via GT two times a day for dementia with behavior disturbance manifested by mood lability, and - dated 10/30/25, for the use of the Depakote (brand name for divalproex), to monitor for dementia with behavioral disturbance manifested by mood lability and tally every shift. * For the use of the escitalopram medication: - dated 8/21/25, to administer escitalopram 10 mg, give one tablet via GT one time day for depression manifested by sad affect, and - dated 8/22/25, for the use of the escitalopram, to monitor the episodes of depression manifested by sad affect and tally every shift. Further review of Resident 7's Order Summary Report failed to show the physician's order to implement NPI for the behaviors of mood lability and sad affect. Review of Resident 7's plan of care showed the following care plan problems: - dated 8/23/25, for Alzheimer's dementia with behavioral disturbance manifested by mood lability. The interventions included to attempt to refocus the behavior to something more positive when the resident was exhibiting the behavior. - dated 8/23/25, for altered mood status related to depression manifested by sad affect. The interventions included to attempt to refocus the behavior to something more positive when the resident is depressed, encourage Resident 7 to express negative and positive emotions and discuss areas of concern, and monitor the episodes of sad affect every shift and record. Further review of the care plans failed to show the interventions to document the nonpharmacological interventions implemented for the observed behaviors and whether the interventions were effective or ineffective. Review of Resident 7's medical record failed to show documented evidence of the licensed nurses' documentation of the NPI implemented for the documented observed behaviors and the effectiveness of the interventions. On 12/9/25 at 1325 hours, an interview was conducted with CNA 2. CNA 2 stated Resident 7 had dementia, was confused and screamed throughout the shift. When asked about the NPI implemented for Resident 7 during her episodes of screaming and confusion, CNA 2 stated he turned on the television, played music in her room, or brought her to activities in the dining room. CNA 2 stated he did not document the interventions provided. On 12/9/25 at 1336 hours, an interview was conducted with LVN 1. LVN 1 stated Resident 7 had periods of being resistant to care and calling out. LVN 1 stated Resident 7 was taking medications and had calmed down. When asked about the NPI implemented for Resident 7, LVN 1 stated Resident 7 liked the television being on and being up in her chair, and seen by the activities staff. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/25 at 1635 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 4. LVN 4 stated the residents on the psychotropic medications were monitored for specific behaviors every shift. LVN 4 stated if the behaviors were observed during the shift, the licensed nurse would implement the NPI and document the interventions implemented in the progress notes. LVN 4 reviewed Resident 4's medical record and verified there was no documentation of the NPI implemented and the effectiveness of the interventions for the documented observed behaviors. On 12/11/25 at 1143 hours, a follow-up interview and concurrent medical record review for Resident 7 was conducted with LVN 1. LVN 1 stated Resident 7 was administered the medication for the behaviors of mood lability and sad affect. When asked about the monitoring of Resident 7's behaviors, LVN 1 stated if the monitored behaviors were observed, the licensed nurse should provide the NPI. LVN 1 reviewed Resident 7's medical record and verified the NPI implemented were not documented for the documented observed behaviors. On 12/11/25 at 1343 hours, an interview and concurrent medical record review for Resident 7 was conducted with the ADON. The ADON stated the licensed nurses were responsible for the monitoring of the manifested behaviors related to the use of the psychotropic medications. The ADON stated the NPI should be implemented for the residents with behaviors. The ADON stated the purpose of the NPI were to determine if the administration of the psychotropic medication was necessary. The ADON stated if the NPI implemented were effective, then the psychotropic medication would not be necessary. The ADON further stated the NPI were implemented and documented only for the residents with the PRN (as needed) psychotropic medications and NPI were not implemented or documented for the residents taking the psychotropic medications routinely. The ADON was informed and acknowledged the above findings. 2. Medical record review for Resident 10 was initiated on 12/11/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's H&P examination dated 3/25/25, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's Order Summary Report dated 12/11/25, showed the following physician's orders: - dated 3/25/25, for buspirone HCl (Hydrocholoride) oral tablet 10 mg, give one tablet by mouth every 12 hours for anxiety manifested by physical and verbal aggression. -dated 5/25/25, for Depakote sprinkles oral capsule delay release sprinkle 125 mg, give two capsules by mouth two times a day for mood disturbance manifested by mood swing from being pleasant to suddenly being distress. -dated 8/21/25, for quetiapine fumarate oral tablet 25 mg, give one tablet by mouth in the evening for psychosis manifested by worsening aggressive inconsolable screaming. -dated 8/21/25, for quetiapine fumarate oral tablet 50 mg, give one tablet by mouth two times a day for psychosis manifested by worsening aggressive inconsolable screaming. -dated 10/1/25, for bupropion HCL oral tablet 75 mg, give one tablet by mouth one time a day for depression manifested by crying spells. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's MAR for December 2025 failed to show documented evidence NPI was provided to the resident for the observed behaviors of screaming, crying spells, physical and verbal aggressions before receiving the buspirone HCL, Depakote, quetiapine and bupropion medications. On 12/11/25 at 1054 hours, a concurrent interview and medical record review for Resident 10 was conducted with LVN 1. LVN 1 verified the above findings. LVN 1 stated the facility staff should document the NPI provided for screaming, crying spells, physical and verbal aggressions. LVN 1 verified the findings and was unable to show documentation of the NPI provided for the use of buspirone HCL, Depakote, quetiapine, and bupropion medications. On 12/11/25 at 1107 hours, an interview and concurrent medical record review for Resident 10 was conducted with the ADON. The ADON verified there was no evidence NPI was provided to the resident. The ADON verified and acknowledged the above findings. 3. Medical record review for Resident 36 was initiated on 12/8/25. Resident 36 was readmitted to the facility on [DATE]. Review of Resident 36's H&P examination dated 1/7/25, showed the resident had the capacity to understand and make decisions. Review of Resident 36's Order Summary Report dated 12/11/25, showed the following physician's orders: - dated 10/1/25, for aripiprazole oral tablet 2 mg give 0.5 tablet by mouth one time a day for depression manifested by mood swings from being pleasant to suddenly being distressed (adjunct treatment to the use of sertraline); and - dated 12/8/25, for sertraline HCL 100 mg at night, give one tablet by mouth at bedtime for depression manifested by verbalization of sadness. Further review of Resident's Order Summary Report failed to show a physician's order to provide NPI prior to the administration of the psychotropic medications. Review of Resident 36's MAR for 12/2025 failed to show documentation of NPI prior to the administration of the psychotropic medications. On 12/11/25 at 1200 hours, an interview and concurrent medical record review for Resident 36 was conducted with LVN 7. LVN 7 verified Resident 36 was receiving aripiprazole and sertraline medications routinely. LVN 7 stated she observed for the side effects, the behavior, or reason why the resident was on the psychotropic medications. On 12/11/25 at 1338 hours, a follow-up interview was conducted with LVN 7. LVN 7 asked if she provided NPI for Resident 36 prior to the administration of the psychotropic medications, and stated, no. LVN 7 stated NPI were only provided prior to the administration of the PRN psychotropic medications. (continued on next page)

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/25 at 1343 hours, an interview was conducted with the ADON regarding psychotropic medications. When asked for the facility's process to address the use of the psychotropic medications, the ADON stated there should be a physician's order, consent, side effects monitoring, care plan, and discussion with the family regarding the risks and benefits of the medication. The ADON also stated the facility had a psychiatrist and the behavior IDT who conducted the medication review. The facility also had a pharmacist consultant who conducted the Drug Regimen Review and made recommendations monthly. When the ADON was asked about NPI for the psychotropic medications, the ADON stated the facility provided NPI for the PRN psychotropic medications. The ADON further stated she did not know what happened because the facility provided NPI for the routine and PRN psychotropic medications ordered because the facility used the information to make sure the medication was necessary for the residents. If the NPI is effective, the resident did not need the medications. The ADON stated there were 22 residents in the facility receiving routine psychotropic medications and verified they were not providing NPI prior to the administration of the routine psychotropic medications.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the pharmacy services as per the facility P&P for one of ten residents (Resident 43) reviewed for pharmacy services. * The facility failed to ensure Resident 43's new order for levetiracetam (antiseizure medication) oral solution was obtained from the pharmacy in a timely manner. (The pharmacy was notified at approximately 0800 hours and the medication was obtained at approximately 1430 hours). * The facility failed to transcribe Resident 43's physician's order for levetiracetam accurately. The physician ordered levetiracetam 1000 mg oral solution medication to be administered twice daily, however, the LVN transcribed the order in error, indicating the levetiracetam 1000 mg oral solution medication was to be administered once daily. These failures posed the risk for inhibiting the therapeutic effects of the medication and had the potential to negatively affect the resident's health. Findings: Review of the facility's P&P titled Ordering and Receiving Medications dated 1/2025 showed the medications shall be ordered and received from the pharmacy on a timely basis. If needed before the next regular delivery, the facility shall phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of the need for prompt delivery and request delivery within four hours. Review of the facility's P&P titled Medication Orders dated 11/2014 showed the purpose of this procedure is to establish uniform guidelines in the receiving and recording of medication orders. When recording orders for medication, specify the type, route, dosage, frequency, and strength of the medication ordered. 1. Medical record review for Resident 43 was initiated on 12/8/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's H&P dated 11/12/25, showed Resident 43 had a diagnosis of seizure disorder. a. Review of Resident 43's Order Summary Report showed a physician's order dated 11/11/25, for levetiracetam 1000 mg tablet orally two times a day for seizures. Review of Resident 43's Administration Note dated 12/10/25 at 0915 hours, showed documentation LVN 5 was waiting for delivery of the levetiracetam 1000 mg oral solution from the pharmacy, and the medication not administered. On 12/10/25 at 1443 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 stated Resident 43 refused her levetiracetam 1000 mg oral tablet this morning, scheduled at 0900 hours. LVN 5 stated Resident 43 would spit out the levetiracetam 1000 mg tablet. LVN 5 stated Resident 43's physician was notified of the refusal of the medication this morning. LVN 5 stated Resident 43's physician changed Resident 43's levetiracetam medication from a tablet to a liquid solution. LVN 5 stated the pharmacy was notified of the new order (at approximately 0800 hours) however, the pharmacy did not deliver the levetiracetam liquid solution until 1430 hours. b. On 12/10/25 at 1455 hours, an interview and concurrent medical record review was conducted with LVN 3. LVN 3 stated she transcribed Resident 43's physician's order, which showed to change Resident 43's levetiracetam 1000 mg from tablet to liquid form. Review of Resident 43's Order Summary Report showed a physician's order dated 12/10/25, for levetiracetam 1000 mg oral solution to be administered daily. However, the order failed to show to administer Resident 43's levetiracetam 1000 mg oral solution in the evening, at 1700 hours. LVN 3 was asked if Resident 43's physician changed the frequency of Resident 43's levetiracetam 1000 mg from twice a day (0900 hours and 1700 hours) to once a day (0900 hours). LVN 3 then reviewed the order she obtained from Resident 43's physician. LVN 3 stated she made an error when she transcribed the order. LVN 3 stated Resident 43's physician ordered levetiracetam 1000 mg oral solution to be administered twice a day at 0900 hours and 1700 hours. LVN 3 stated she would correct her transcription error. Cross reference F842 example 1.

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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	**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 safety and sanitation requirements were met in the kitchen. * The facility failed to ensure the kitchen equipment were kept in sanitary conditions. * The facility failed to ensure the food preparation equipment was in good condition. * The facility failed to ensure the food was past the use-by date were discarded. * The facility failed to ensure the food brought from outside was properly labeled and stored as per the facility's P&P. * The facility failed to ensure a food preparation sink had an air gap for back flow prevention. These failures had the potential for exposure to food-borne illnesses for a medical vulnerable population of 42 residents who received food prepared in the kitchen.Findings: Review of the facility document titled Resident Summary Report dated 12/8/25, showed 42 of 43 residents who consumed food prepared in the kitchen. 1. According to the 2022 FDA Food Code Section 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surfaces, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. According to the 2022 FDA Food Code Section 4-602.13, Non-Contact Surfaces, the presence of food debris or dirt on nonfood contact surfaces may provide a suitable environment for the growth of microorganisms which employees may inadvertently transfer to food. If these areas are not kept clean, they may also provide harborage for insect, rodents, and other pests. Review of the facility's P&P titled Stove Hood Policy (undated) showed proper stove hood maintenance reduces fire hazards, prevents grease build up and supports infection control in food service areas. The stove hoods must be kept free of grease, dust, and debris at all times. Review of the facility's P&P titled Refrigerator Cleaning P&P (undated) showed to maintain safe, sanitary conditions in the refrigerators and walk- ins, prevent microbial growth and to avoid cross contamination. During the initial kitchen tour on 12/8/25 at 0755 hours, an observation and concurrent interview was conducted with the DSS. The following was observed:- the stove hood was wiped with a paper towel and observed with grey sticky residue on the paper towel.- the fans inside of Refrigerator A were observed with greyish black fuzzy substance. A paper towel was used to wipe the fam and was observed with greyish black substance. The fans were observed directly above multiple pitchers of juices with the spout uncovered. The DSS verified the above findings. 2. According to the 2022 FDA Food Code Section 4-202.11, multi-use food contact surfaces shall be smooth; free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; free of sharp internal angles, corners, and crevices; and finished to have smooth welds and joints. Review of the facility's P&P titled Cleaning & Sanitation Frequency (undated) showed the equipment no longer in good repair and not able to be properly cleaned/sanitized, will be replaced as necessary. During the initial kitchen tour on 12/8/25 at 0755 hours, an observation and concurrent interview was conducted with the DSS. The can opener blade was observed with the chipped stainless-steel coating, exposing the blade. The DSS verified the above findings. 3. Review of the facility's P&P titled Labeling and Dating dated 1/2023 showed all food items are properly labeled and dated based on the food storage guidelines to maintain food safety and prevent spoilage. To include on the label the food name, preparation date, and if required, opened or use by date. To discard food immediately after reaching the use-by date or if spoiled. On 12/8/25 at 0755 hours, during the initial tour of the kitchen, an observation of Refrigerator B was conducted with the DSS. A container of diced onions was observed with the use-by date of 12/7/25. The DSS verified the above findings. 4. Review of the facility's P&P titled Outside Food (undated) showed any food which is not to be eaten right away should be stored in a disposable, sealed container supplied by the visitor in the refrigerator/freezer. Food must be labeled with the resident's name and date it was [NAME] to the facility and stored in the resident's refrigerator. Unconsumed food will be disposed of consistent with the manufacturer guidelines, food labels or upon evidence of spoilage. Left-over food shall be discarded within three days, condiments and other appropriate items may be kept until the manufacturer expiration date. Review of the facility's document titled Refrigerator/Freezer (undated) showed please label resident's personal food and drinks with: 1. Resident's name, and 2. Today's date. Ready to eat/prepared foods/drinks can be kept in the refrigerator for 72 hours. After 72 hours t will be discarded. Items with manufacturer's toss by/best-by/expiration date available would be adhered to. On 12/8/25 at 947 hours, an observation of the

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 maintain an accurate medical record for three of 13 final sampled residents (Residents 10, 29, and 43). * The facility failed to ensure the episodes of crying spells documented on the MAR were accurate for Resident 10. * The facility failed to ensure the skin assessment was documented accurately to reflect the bruising identified for Resident 29. * The licensed nurse documented Resident 43 received levetiracetam (antiepileptic mediation) 1000 mg tablet orally on 12/10/25 at 0900 hours, however, Resident 43 had refused the medication. These failures had the potential for the residents' care needs not being met as their medical information was inaccurate.Findings: 1. Medical record review for Resident 43 was initiated on 12/8/25. Resident 43 was admitted to the facility on [DATE]. Review of Resident 43's Order Summary Report showed a physician's order dated 11/11/25, for levetiracetam 1000 mg tablet orally two times a day for seizures. Review of Resident 43's H&P dated 11/12/25, showed Resident 43 had a diagnosis of seizure disorder. On 12/10/25 at 1443 hours, an interview and concurrent medical record review was conducted with LVN 5. LVN 5 stated Resident 43 had refused her levetiracetam 1000 mg oral tablet this morning, which was scheduled at 0900 hours. LVN 5 said Resident 43 would spit out the levetiracetam 1000 mg tablet. LVN 5 stated Resident 43's physician was notified of the refusal this morning and subsequently changed the levetiracetam 1000 mg from tablet to a liquid form. However, review of Resident 43's MAR dated 12/2025 showed LVN 5 administered Resident 43's levetiracetam 1000 mg oral tablet on 12/10/25 at 0900 hours. LVN 5 verified the findings and stated Resident 43's MAR would be corrected. 2. Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective (not opiniated or speculative), complete and accurate. Medical record review for Resident 10 was initiated on 12/11/25. Resident 10 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 10's Order Summary showed an order dated 3/24/25, to monitor depression manifested by crying spells every shift, tally by hashmark every shift for depression. Review of Resident 10's H&P examination dated 3/25/25, showed Resident 10 had no capacity to understand and make decisions. Review of Resident 10's MAR for November 2025 showed on 11/16/25, there were 97 episodes of crying spells documented during the evening shift. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/25 at 0803 hours, an interview and concurrent medical record review for Resident 10 was conducted with LVN 2. LVN 2 stated the number of crying spells documented for 11/16/25, was an error because it was only seven episodes. LVN 2 stated the MAR was mistakenly documented as 97 episodes instead of seven episodes of crying spells. LVN 2 acknowledged and verified the above findings. On 12/11/25 at 0823 hours, an interview and concurrent medical record review for Resident 10 was conducted with the ADON. The ADON verified the MAR showed 97 episodes of crying spells on 11/16/25, during the evening shift and stated it was an error. The ADON stated license nurses were expected to assess and document accurately on the residents' medical record. 3. Medical record review for Resident 29 was initiated on 12/8/25. Resident 29 was admitted to the facility on [DATE]. Review of Resident 29's Admit/Readmit Screener 4.0 dated 11/25/25, showed bruising on the BUE (bilateral upper extremities). Review of Resident 29's H&P examination dated 11/26/25, showed the resident was able to make her own decisions and needs known. Review of Resident 29's Order Summary Report showed the following physician's orders: - dated 11/25/25, skin discoloration LUE (left upper extremity). Observe for signs and symptoms of swelling, skin breakdown, and bleeding every shift for 30 days; - dated 11/25/25, skin discoloration RUE (right upper extremity). Observe for signs and symptoms of swelling, skin breakdown, and bleeding every shift for 30 days; - dated 11/25/25, aspirin tablet (blood thinner to prevent heart attacks and strokes) 81 mg give one tablet by mouth one time a day for CVA prophylaxis. Take with food; - dated 11/25/25, Clopidogrel bisulfate (blood thinner) tablet 75 mg give one tablet by mouth one time a day for CAD; and - dated 11/26/25, to monitor for signs and symptoms for adverse bleeding like bruising, bleeding gums, nose bleed, petechiae, hematuria, melena, heavy bleeding, black tarry stools, coffee ground emesis. If symptoms occur document and notify MD. If present mark Y, if none mark N, every shift for monitoring. Review of Resident 29's handwritten skin assessment record showed on 12/2/25, the resident had an old discoloration on chest and wrist. On 12/3/25, the assessment showed the resident's skin clear. On the same date, another assessment showed the resident had an old discoloration on the chest and abdominal area. The skin assessment dated [DATE] was blank, and another assessment for the same date showed old skin discoloration with no specific area marked on the body diagram. On 12/6/25, the skin assessment showed old discoloration. The skin assessments dated 12/7/25, showed the resident had clear skin. Resident 29's medical record failed to show documentation the physician was notified when the assessments showed clear skin to having bruises identified. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/11/25 at 1425 hours, an interview and concurrent medical record review for Resident 29 was conducted with the ADON. The ADON verified the findings and stated the resident's physician was not notified of the bruising because the resident was admitted with the bruising from the acute care hospital and it was a documentation error from the CNAs. On 12/11/25 at 1550 hours, an interview was conducted with the Administrator, DON, and ADON. The Administrator, DON, and ADON were informed of the findings and acknowledged the findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **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 implement their infection control program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program from January 2025 through November 2025. The facility conducted surveillance of resident infections based on whether the residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and symptoms of infection and were not prescribed antimicrobial medications met the facility's criteria for infection (utilizing McGeer's Criteria). The facility failed to include these residents in the facility's infection control surveillance program. This failure posed the risk for not identifying resident infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility. * The facility failed to establish specific testing protocols and acceptable ranges for control measures, to reduce Legionella risk. This failure posed the risk for Legionella growth in the facility building water system. Legionella has the potential to cause a serious type of pneumonia called Legionnaires disease in the vulnerable resident population. * The facility failed to ensure CNA 2 wore the proper PPE (Personal Protective Equipment) when making contact with Resident 7 and repositioning Resident 7's pillow. Resident 7 was on EBP (Evidence-Based Practice) for her GT (Gastrostomy Tube). *The facility failed to ensure Resident 29 was offered hand hygiene before eating lunch. These failures had the potential for the spread of infection to the residents, staff, and visitors in the facility.Findings: 1. Review of the facility's P&P titled Surveillance for Infections revised 9/2017 showed the IP will conduct ongoing surveillance for HAIs (Healthcare-Associated Infections) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions. The purpose of the surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and HAIs, to guide appropriate interventions, and to prevent future infections. Infections that will be included in routine surveillance include those with evidence of transmissibility in a healthcare environment and pathogens associated with serious outbreaks Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. The nurse in charge will notify the attending physician and the IP of suspected infections. The IP is responsible for gathering and interpreting surveillance data. Collect information monthly from individual resident infection reports and enter line listing of infections by resident for the entire month. Analyze the data to identify trends. Consider how increases or decreases might relate to recent process changes, events, or activities in the facility. On 12/8/25 at 0904 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's resident infection surveillance program. The IP stated she was responsible for the surveillance of resident infections in the facility. The IP stated the purpose of infection surveillance was to identify individual resident infections and trends of epidemiologically significant organisms and HAIs, to guide appropriate facility interventions, and to prevent future infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP stated when a resident exhibited signs and/or symptoms of an infection, the nurse would perform a change of condition assessment. The nurse would then contact the resident's physician and inform the physician of the signs and/or symptoms of infection the resident exhibited. The IP stated if the resident's physician prescribed an antibiotic, then the nurse would initiate the McGeer's Criteria form. The IP stated the facility utilized McGeer's criteria to determine if a resident had an infection. The IP stated she would include these residents in the facility's infection surveillance program and document on the facility's Monthly Infection Prevention and Control Surveillance log. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2025 through November 2025, showed the following infection surveillance data for HAIs, CAIs (Community-acquired infections), and resident who did not meet McGeer's Criteria (DNMC): - 1/2025, HAI – 10, CAI – 22, and DNMC - 1 - 2/2025, HAI – 7, CAI – 11, and DNMC - 1 - 3/2025, HAI – 4, CAI – 13, and DNMC - 3 - 4/2025, HAI – 7, CAI – 14, and DNMC - 0 - 5/2025, HAI - 6, CAI – 12, and DNMC - 2 - 6/2025, HAI - 6, CAI – 9, and DNMC - 5 - 7/2025, HAI – 6, CAI – 9, and DNMC - 3 - 8/2025, HAI - 8, CAI – 13, and DNMC - 3 - 9/2025, HAI - 4, CAI – 6, and DNMC - 2 - 10/2025, HAI -2, CAI – 9, and DNMC - 1 - 11/2025, HAI - 2, CAI – 15, and DNMC – 2 The IP was asked when a resident at the facility exhibited signs and/or symptoms of infection and was not prescribed antimicrobial medications, if the facility initiated the McGeer's criteria form for these residents and included these residents in the facility's infection surveillance program (from January 2025 to November 2025). The IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications. The IP stated only a change of condition assessment was performed for these residents. The IP was asked how many residents in the facility had infections (met McGeer's criteria) and were not prescribed antimicrobial medications (from January 2025 through November 2025). The IP stated she was uncertain as the facility did not initiate the McGeer's criteria form for residents who exhibited signs and/or symptoms of infections and were not prescribed antimicrobial medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555718	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. According to the CMS QSO 17-30 titled Requirement to Reduce Legionella Risk in Healthcare Facility Water Systems to Prevent Cases and Outbreaks of Legionnaire's Disease dated 6/2/17, the facilities must develop and adhere to the policies and procedures that inhibit microbial growth in building water systems that reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. These facilities must have water management plans and documentation that, at a minimum, ensure each facility: * Conducts a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous mycobacteria, and fungi) could grow and spread in the facility water system. * Develops and implements a water management program that considers the ASHRAE (American Society of Heating Refrigerating and Air-Conditioning Engineers) industry standards and the CDC toolkit; and * Specifies testing protocols and acceptable ranges for control measures and documents the results of testing and corrective actions when control limits are not maintained. Review of the facility's P&P titled Legionella Water Management Program revised 7/2017 showed the facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) recommendations for developing a Legionella water management program. The water management program includes the following elements: Specific measures used to control the introduction and/or spread of legionella (e.g., temperature, disinfectants). The control limits or parameters that are acceptable and that are monitored. A diagram of where control measures are applied. A system to monitor control limits and the effectiveness of control measures. A plan for when control limits are not met and/or control measures are not effective, and documentation of the program. On 12/11/25 at 1030 hours, an interview and concurrent facility document review was conducted with the Administrator and Maintenance Technician. Review of the facility's Water Management Program dated 10/2022 and the facility's Procedures for Monitoring and Inspection for possible Legionella Disease Bacteria Growth dated 5/19/23, failed to show specific testing protocols and acceptable ranges for control measures to reduce Legionella risk. The Administrator and Maintenance Technician verified the facility failed to establish specific testing protocols and acceptable ranges for control measures, to reduce Legionella risk. 3. Review of the facility's P&P titled Enhanced Barrier Precautions revised 12/2024, showed EBPs refer to infection prevention and control interventions designed to reduce the transmission of MDROs during high contact resident care activities. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activates when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activities (as opposed to before entering the room). Examples of high contact resident care activities requiring the use of the gown and gloves for EBPs include: (continued on next page)

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Rowntree Gardens	12151 Dale Avenue Stanton, CA 90680

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. dressing; b. bathing/showering; c. providing hygiene or grooming; d. changing briefs or assisting with toileting e. transferring; f. providing bed mobility; g. changing linens; h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin; i. device care of use; and j. wound care. Medical record review for Resident 7 was initiated on 12/8/25. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's Order Summary Report showed a physician's order dated 8/22/25, to implement the EBP related to the presence of the GT. On 12/9/25 at 1100 hours, an observation and concurrent interview was conducted with CNA 2. CNA 2 entered Resident 7's room, touched and fluffed Resident 7's pillow on the bed, and then placed the pillow behind Resident 7, who was sitting in her wheelchair. CNA 2 placed his hands on Resident 7's shoulders to move her forward and moved the pillow behind Resident 7's head and shoulders. CNA 2 was not wearing a gown. CNA 2 stated Resident 7 was on EBP for her GT. CNA 2 stated for the residents on EBP, the staff should wear the gown and gloves when providing direct care to the resident. CNA 2 verified the above findings and stated he should have worn a gown. On 12/10/25 at 1125 hours, an interview was conducted with the IP. The IP stated for the residents on EBP, upon entering the resident's room to provide care or when touching the resident's surroundings, the facility staff was expected to don the gown and gloves to prevent the transmission of organisms to others. The IP was informed and acknowledged the above findings. 4. Review of the facility's P&P titled Handwashing/Hand Hygiene, undated, showed this facility considers hand hygiene the primary means to prevent the spread of infections. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for situations including before and after eating or handling food (Policy Interpretation and Implementation #7, Section O). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medical record review for Resident 29 was initiated on 12/8/25. Resident 29 was admitted to the facility on [DATE]. On 12/8/25 at 1150 hours, a lunch meal observation for Resident 29 was conducted in her room. The DSD brought the resident's lunch tray, placed it on the bedside table and lifted the cover of the main plate. The DSD was not observed and heard offering hand hygiene to Resident 29 prior to eating her lunch. On 12/8/25 at 1204 hours, an interview was conducted with Resident 29. Resident 29 stated her lunch was good. When asked if she was offered hand hygiene by staff prior to eating lunch, Resident 29 picked up the sealed packet of Fresh Nap hand wipe from her stray and stated, I use it after I eat. I use it every day after I eat. When asked if the staff asked her to clean or wash her hands prior to eating, Resident 29 stated, no. On 12/10/25 at 1347 hours, an interview was conducted with the DSD. When asked for the facility's process before the meal tray was handed to the resident, the DSD stated she knocked on the door, introduced herself, informed the resident the tray was there, opened the hand wipe for the resident before the resident ate. When the DSD was informed she was not observed offering hand hygiene to Resident 29 on 12/8/25, during lunch observation, she stated, I did. The DSD was informed Resident 29 was observed from the time the lunch tray was delivered to the resident until the resident finished her meal and showed the sealed Fresh Nap hand wipe. The DSD acknowledged the findings. On 12/11/25 at 1550 hours, an interview was conducted with the Administrator, DON, and ADON. The Administrator, DON, and ADON were informed of the findings and acknowledged the findings.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview, facility document review, and facility P&P review, the facility failed to implement the antibiotic stewardship program in accordance with their P&P. * The facility initiated McGeer's criteria after the residents' physician prescribed antibiotics rather than attempting to make the determination whether a resident who exhibited signs and symptoms of infection, had met McGeer's criteria before contacting the physician. This failure posed the risk for the continued use of unnecessary antibiotics, potentially resulting in adverse reactions associated with antibiotics, and the development of antibiotic-resistant bacteria.Findings: Antibiotics are among the most frequently prescribed medications in nursing homes. According to the CDC, an estimated 70% of nursing home residents receive one or more courses of antibiotics during a year. Studies have shown that 40% to 75% of the antibiotics prescribed in nursing homes may be unnecessary or inappropriate. Frail and older adults are at significant risk of harm from antibiotic overuse including increased adverse drug events, increased drug interactions and infection with antibiotic-resistant organisms. The WHO cites antibiotic resistance as one of the three biggest threats to human health. Review of the facility's P&P titled Antibiotic Stewardship - Orders for Antibiotics revised 12/2016 showed the antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program and in conjunction with the facility's general policy for medication utilization and prescribing. Prior to calling a physician/prescriber to communicate a suspected infection, the nurse will obtain and have the following information available: Clinical signs and symptoms of suspected infection (based on approved definitions of infection). Appropriate indications for use of antibiotics include: criteria met for clinical definition of active infection. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from January 2025 through November 2025 showed the following infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's Criteria (DNMC): - 1/2025, HAI - 10, CAI - 22, and DNMC - 1- 2/2025, HAI - 7, CAI - 11, and DNMC - 1- 3/2025, HAI - 4, CAI - 13, and DNMC - 3- 4/2025, HAI - 7, CAI - 14, and DNMC - 0- 5/2025, HAI - 6, CAI - 12, and DNMC - 2- 6/2025, HAI - 6, CAI - 9, and DNMC - 5- 7/2025, HAI - 6, CAI - 9, and DNMC - 3- 8/2025, HAI - 8, CAI - 13, and DNMC - 3- 9/2025, HAI - 4, CAI - 6, and DNMC - 2- 10/2025, HAI -2, CAI - 9, and DNMC - 1- 11/2025, HAI - 2, CAI - 15, and DNMC - 2 On 12/8/25 at 0904 hours, an interview and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's Antibiotic Stewardship program (from January 2025 through November 2025) specific to the use of McGeer's Criteria and the physician prescription of antibiotics. The IP stated when a resident exhibited signs and/or symptoms of an infection the licensed nurse would conduct a change of condition assessment and notify the physician of the signs and/or symptoms of infection the resident exhibited. The IP stated if the physician then prescribed antibiotics, the licensed nurse who received the antibiotic order would initiate the facility's McGeer's criteria form. The IP stated the facility utilized the McGeer's criteria to determine if a resident had an infection. The IP was asked in accordance with the facility's P&P titled Antibiotic Stewardship - Orders for Antibiotics revised 12/2016 if a resident exhibited signs and/or symptoms of infection (in addition to a change of condition assessment) should the nurse also initiate the McGeer's criteria form to determine whether the resident had a true infection. Which would allow the licensed nurse to convey to the physician/prescriber the resident may not have met the criteria for a true infection, thus providing the physician/prescriber the opportunity not to prescribe antibiotics, unnecessarily for a resident who did not meet the facility's criteria for infection. The IP stated the facility did not initiate the McGeer's criteria form for the residents who exhibited signs and/or symptoms of infection until after the resident's physician prescribed antibiotics (from January 2025 through November 2025).