STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Alvarado Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1154 S.Alvarado St Los Angeles, CA 90006	

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain an informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) from the resident or their responsible party (a person delegated to make medical decisions for the resident in the event they are unable to do so) prior to the treatment with Cymbalta (a medication used to treat mental illness) in one of five sampled residents (Resident 69) for unnecessary medications.The deficient practice of failing to obtain an informed consent prior to initiating treatment with a psychotropic (medications that affect brain activities associated with mental processed and behavior) medications could have prevented Resident 69 from exercising her right to decline treatment with Cymbalta. This increased the risk that Resident 69 could have experienced adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to Cymbalta leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 69's admission Record (a record containing diagnostic and demographic resident information), the admission Record indicated the facility admitted Resident 69 on 4/9/2025 with a diagnosis of schizophrenia (a mental illness characterized by hearing or seeing things that are not there). During a review of Resident 69's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 4/10/2025, the H&P indicated Resident 69 had capacity to understand and make medical decisions. During a review of Resident 69's Order Summary Report (a summary of all current physician orders) dated 1/22/2026, the Order Summary indicated on 5/7/2025, Resident 69's attending physician prescribed Cymbalta 30 milligrams (mg - a unit of measure for mass) by mouth at bedtime for phantom limb pain (nerve-related pain due to an amputation.) During a review of Resident 69's available informed consent documentation and clinical record indicated there was no documentation that Resident 69 or any responsible party received education regarding the risks and benefits of Cymbalta prior to its initiation on 5/7/2025. During an interview on 1/22/2026 at 11:52 AM with the Director of Nursing (DON), the DON stated the facility failed to obtain informed consent for the use of Resident 69's Cymbalta prior to its use. The DON stated he (DON) was unaware Cymbalta needed an informed consent as it was not being used for behavioral management. The DON stated failure to obtain an informed consent could deprive Resident 69 of her right to decline psychotropic treatment possibly leading to a decline in her quality of life. During a review of the facility's policy Psychotherapeutic Drug Management, revised 5/19/2025, the policy indicated When obtaining consent for the use of psychotherapeutic drugs, the resident will be informed of the risks and benefits for the use of these medications.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on interview and record review the facility failed to provide feeding assistance during meals for one of three sampled residents (Resident 69). This deficient practice had the potential not to meet Resident 69's specific needs and had the potential for Resident 69's activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) to decline.Findings:During a review of Resident 69's admission Record, the admission Record indicated the facility admitted Resident 69 on 4/9/2025 with diagnoses that included unqualified visual loss (a significant loss of vision in one or both eyes where the specific cause[blindness category, underlying disease] has not been clearly identified) both eyes, unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance (acting out, agitated, aggressive or mood/personality changes), psychotic disturbance(hallucinations or strong delusions), mood disturbance (disruptive sadness, irritability), and anxiety (excessive worry, fear, and nervousness), other lack of coordination(the brain struggles to coordinate muscles, leading to jerky, unsteady, or inaccurate movements), dysphagia (difficulty swallowing), oral (mouth) phase and cognitive communication deficit (struggling with talking, listening, or understanding because of problems with thinking skills[cognition], rather than a physical speech or language issue). During a review of Resident 69's History and Physical dated 4/10/2025, the H&P indicated Resident 69 had the capacity (ability) to make medical decisions. During a review of Resident 69's Optometry Exam Consult dated 8/13/2025 indicated Resident 69 had vision loss in both eyes and had an inability to adapt to bifocals (eyeglasses with split into two parts to correct both far and near vision in one frame). The Optometry Exam Consult indicated Resident 69 had cataracts (a clouding of your eyes' natural lens, like looking through a foggy window, which makes vision blurry and hazy). During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 10/14/2025, the MDS indicated Resident 69 had severely impaired (reduced) vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects), did not use corrective lenses (contacts, glasses, or magnifying glass), had normal cognition (ability to think, understand, learn, and remember), had limitation in range of motion (ROM-the full distance and direction a joint[where two or more bones meet] can move, measured by how far it can bend, straighten, or twist) in the upper extremity (shoulder, elbow, wrist, hand) on one side and required supervision or touching assistance (helper provides verbal cues[short spoken words used as a guide] and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating . During a review of Resident 69's Speech Therapy note dated 11/7/2025 indicated Resident 69 required set up and intermittent cues (occasional reminders) for identification location of food items on meal tray due to have been diagnosed of being legally blind (severe uncorrectable vision loss) and benefitted from verbal cues upon meal tray set up and also finger foods. During a review of Resident 69's Dietary Profile dated 1/13/2026 indicated Resident 69 was blind and was able to feed self with supervision and maximum assist. During an observation on 1/20/2026 at 12:55 PM Resident 69 was observed in the dining room sitting in a wheelchair and eating lunch unassisted by staff. Resident 30 was observed sitting beside Resident 69 and intermittently scooping up Resident 69's food into mounds on the plate and Resident 69 preceded to scoop up another spoonful of food to eat. Certified Nurse Assistant 1 (CNA 1) was observed sitting at the same table and was assisting another resident (unidentified) with their meal. CNA 1 did not assist Resident 69. During an interview on 1/20/2026 at 1:17 PM with Resident 69, Resident 69 stated I cannot see, I only see light in my eyes. I have cataracts in my eyes. I needed help but no other person had assisted me. During a concurrent interview and record review on 1/20/2026 at 1:23 PM, with the Infection Preventionist (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(IP), Resident 69's Dietary Profile dated 1/13/2026 was reviewed. The IP stated, any staff member that was in the dining area could have assisted [Resident 69], but I did not have anyone that helped her today with her meal. The IP stated I had asked [Resident 69] if she wanted assistance with her meal, but [Resident 69] stated she did not want any help. The IP stated Resident 69 would usually refuse assistance with her meal. The IP stated she (IP) informed Resident 30 he (Resident 30) could not help Resident 69 with her meal, and he (Resident 30) stopped. The IP stated Resident 69's Dietary Profile indicated Resident 69 required maximum assistance and supervision with eating. The IP stated there was not any documentation of Resident 69 refusing assistance with meals. During an interview on 1/20/2025 at 2:24 PM, with CNA1, CNA 1stated he (CNA1) did not assist Resident 69 and was not assigned to Resident 69. CNA 1 stated Resident 69 could only see shadows. CNA 1 stated he (CNA1) saw the other resident (Resident 30) helping her (Resident 69). During a concurrent interview and record review on 1/21/2026 at 12:14 PM, with the IP, the facility's policy and procedure (P&P) titled, Care Planning dated 2/17/2025 and the facility's policy and procedure (P&P) titled, Resident Rights-Accommodation of Needs dated 2/17/2025 were reviewed. The IP stated an interdisciplinary team meeting (IDT, a collaborative group of diverse health care professionals from different fields who work together) should have been done for Resident 69's accommodation of requiring assistance with her meals as indicated on the policy. The IP stated there was no IDT done for Resident 69's accommodation of having needed assistance and to find out why the resident was refusing assistance for meals that needed to be addressed. The IP stated the policies for care planning and resident accommodation were not followed as indicated since a care plan was not developed and Resident 69 was not assisted during meals. During a concurrent interview and record review on 1/21/2026 at 12:21 PM, with Registered Nurse 1 (RN1), the facility's policy and procedures (P&P) titled, Care Planning dated 2/17/2025 and the facility's policy and procedure (P&P) titled, Resident Rights-Accommodation of Needs dated 2/17/2025 and Resident 69's complete Care Plan Report were reviewed. RN 1 stated Resident 69 could only see shadows and was able to feed herself but required verbal cues during meals for location of food which was considered an accommodation. RN 1 stated there was no IDT done for Resident 69 having required accommodation of supervision or touch assistance with meals. RN 1 stated an IDT needed to have been done and it was important to have known the results of the IDT for Resident 69's care. RN 1 stated an IDT was not done for Resident 69's to have needed assistance during meals or having refused assistance. RN 1 stated there was no care plan for Resident 69 accommodation needing supervision or touch assistance with meals. RN 1 did not want to answer if the facility was following the policy and procedure on accommodation needs and care planning. During a concurrent interview and record review on 1/21/2026 at 12:46 PM, with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Care Planning dated 2/17/2025 and the facility's policy and procedure (P&P) titled, Resident Rights-Accommodation of Needs dated 2/17/2025 were reviewed. The DON stated it was not appropriate for another resident to help Resident 69 with her meal; the staff should have assisted Resident 69, that was part of the resident's accommodation. The DON stated there was no IDT done for Resident 69 needing accommodation for assistance with meals or having refused assistance. The DON stated the IDT was members of every department meeting to have assessed concerns for residents and to have created a person-centered care plan per policy. The DON stated there was not a care plan for Resident 69 indicating Resident 69 required supervision or touch assistance with meals or a care plan for that accommodation. The DON stated the consequence of not having a care plan was that there would not be an identification of resident's needs to better help Resident 69. The DON stated any licensed nurse could create a care plan and the IDT could have created a care plan based on the policy; the IDT could (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have addressed the reason behind Resident 69's refusal of assistance with meals. The DON stated the purpose of a care plan was to have interventions in place to have problems addressed and plan for resident care with goals in mind. The DON stated we needed to accommodate Resident 69's needs in her ADL's, especially with meals since that is very specific and can lead to an alteration in the resident's nutrition. The DON stated the facility did not follow policies on care planning or resident accommodation of needs. During a review of the facility's policy and procedure (P&P) titled, Care Planning dated 2/17/2025, the P&P indicated The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan. The P&P indicated A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/MDS guidelines. The P&P indicated Each Resident's Comprehensive Care Plan will describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Accommodation of Needs dated 2/17/2025, the P&P indicated To ensure that the Facility provides an environment and services that meet residents' individual needs. The P&P indicated Facility Staff interacts with the residents in a way that accommodates the physical or sensory limitations of the residents.

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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. Based on interview and record review, the facility failed to:-Ensure Risperdal (a medication used to treat mental illness) was used to treat a medical diagnosis clearly documented in the medical record for one of five residents (Resident 1) sampled for unnecessary medications-Define specific problematic behaviors related to the use of Risperdal and Depakote (a medication used to treat mental illness) for one of five sampled residents (Resident 69) for unnecessary medications (Resident 69).-Monitor for adverse effects (unwanted or dangerous medication-related side effects) related to the use of Cymbalta (a medication used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 69.)The deficient practices of failing to define specific problematic behaviors, ensure medication was used to treat a resident's specific, diagnosed condition, and monitor adverse effects related to the use of psychotropic medications (medications that affect brain activities associated with mental processes and behavior) increased the risk that Residents 1 and 69 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status.Findings:a. During a review of Resident 1's admission Record (a record containing diagnostic and demographic resident information), the admission Record indicated the facility admitted Resident 1 on 9/14/2011 and readmitted Resident 1 on 12/21/2025 with a diagnosis of dementia (a loss of mental ability that affects memory, thinking, and behavior to the point that it interferes with daily life). During a review of Resident 1's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 12/23/2025, the H&P indicated Resident 1 had capacity to understand and make medical decisions. During a review of Resident 1's follow-up psychiatric note, dated 12/27/2025, the follow-up psychiatric note indicated Resident 1's diagnosis related to the use of Risperdal was schizoaffective disorder (a mental illness characterized by seeing or hearing things that are not there, paranoid delusions, and mood swings. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) assessment (a periodic comprehensive resident assessment performed by facility staff), dated 12/28/2025, the MDS Section I (active diagnoses) indicated Resident 1 did not have a diagnosis of bipolar disorder. During a review of Resident 1's care plan related to the use of Risperdal, last revised 1/7/2026, the care plan indicated on 10/27/2022 Resident 1 was using Risperdal to treat a diagnosis of schizophrenia and was later updated on 12/11/2024 to bipolar disorder. During a review of Resident 1's Order Summary Report (a summary of all current physician orders) dated 1/22/2026, the Order Summary indicated Resident 1's attending physician prescribed Risperdal 1.5 mg by mouth one time a day for bipolar disorder (a mental illness characterized by extreme mood swings ranging for depressed lows to manic highs) manifested by throwing objects, fighting with staff on 12/22/2025. During an interview on 1/22/2026 at 12:05 PM with the Director of Nursing (DON), the DON stated the facility failed to ensure Resident 1's Risperdal was used for a clear diagnosis as documented in the clinical record. The DON stated the clinical record included diagnoses of bipolar disorder, schizophrenia, and schizoaffective disorders all tied to his use of Risperdal. The DON stated this makes the true use of the medication unclear. The DON stated not having a clearly defined diagnosis related to the use of psychotropic medication increases the risk that Resident 1 may experience a decline in the quality of life because of medication-related adverse effects. During a review of the facility's policy titled Psychotherapeutic Drug Management revised 5/19/2025, the policy indicated The psychotherapeutic medication order will include the following information. diagnosis for the medication. indications and manifestations of the disorder treated (i.e. auditory hallucinations, (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hitting others, refusing to eat, etc.) Nursing responsibility. will monitor psychotropic drug use daily noting any adverse effects (i.e. EPS, Tardive dyskinesia, excessive dose or distressed behavior). b. During a review of Resident 69's admission Record, the admission Record indicated the facility admitted Resident 69 on 4/9/2025 with diagnoses including schizophrenia (a mental illness characterized by hearing or seeing things that are not there.) During a review of Resident 69's H&P dated 4/10/2025, the H&P indicated Resident 69 had capacity to understand and make medical decisions. During a review of Resident 69's follow-up psychiatric note (a record of a psychiatric provider's psychiatric assessment and plan) dated 12/8/2025, the follow-up psychiatric note indicated there was no discussion of Resident 69's problematic behaviors or specific examples related to her diagnosis of schizophrenia but that staff should report any unwanted behavior and continue monitoring the patient closely. During a review of Resident 69's available care plans (a plan of care individualized to a resident's specific needs), last revised 1/15/2026, indicated there were no care plans created to address Resident 69's disruptive behavior or aggressive behavior related to a diagnosis of schizophrenia. Further review of the available care plans indicated the care plans for the use of Risperdal and Depakote to treat aggressive behavior and disruptive behavior did not provide any specific examples of Resident 69's manifestations of the problematic behaviors, no individualized non-pharmacological approaches to address these behaviors, or any Resident-centered therapeutic goals for the reduction of these behaviors related to the use of psychotropic medications. During a review of Resident 69's Order Summary Report dated 1/22/2026, the Order Summary indicated Resident 69's attending physician prescribed the following psychotropic medication therapy:1.Risperdal 2 mg by mouth twice a day for schizophrenia manifested by disruptive behavior on 4/9/2025.2. Cymbalta 30 mg by mouth at bedtime for phantom limb pain (nerve-related pain due to an amputation) on 5/720/25.3.Depakote 750 mg by mouth three times daily for schizophrenia manifested by aggressive behavior on 9/29/2025. During a review of Resident 69's Medication Administration Record (MAR - a daily record of medications administered, and monitoring performed for a resident) for January 2026, the MAR indicated there were no specific examples of aggressive or disruptive behaviors defined in the behavioral monitoring orders to allow licensed staff to effectively monitor and quantify the problematic behaviors. Further Review of the MAR indicated there was no monitoring done for adverse effects related to the use of Cymbalta. During an interview on 1/22/26 at 11:52 AM with the DON, the DON stated the behaviors for Resident 69's Risperdal and Depakote are vague and should be defined more specifically so nursing staff could monitor appropriately for the problematic behaviors. The DON stated the failure to adequately define problematic behaviors related to the use of psychotropic medication could lead to Resident 69 being on Risperdal or Depakote longer than necessary possibly leading to a decline in her quality of life due to medication adverse effects. The DON stated the facility also failed to monitor adverse effects related to the use of Cymbalta. The DON stated Cymbalta and other psychotropics must be monitored for adverse effects to continually ensure that the benefits of the medication outweigh the risks. The DON stated failing to monitor adverse effects of psychotropic medications could result in Resident 69 experiencing more adverse effects than necessary possibly leading to a decline in her quality of life.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS - a comprehensive resident assessment tool) assessment Section I (active diagnoses) by failing to include diagnoses of bipolar disorder (a mental illness characterized by having rapid changes in mood from depression to mania) and depression (a mental illness characterized by depressed mood, insomnia, and lack of energy or interest in usually enjoyable activities) per information in the medical record for two of five residents sampled for unnecessary medications (Resident 1 and Resident 69).The deficient practice of failing to accurately assess active diagnoses and complete MDS Section I increased the risk that Resident 1 and Resident 69 may not have received care planning and treatment according to their needs possibly leading to a decline in their overall health and well-being. Findings:During a review of Resident 1's admission Record (a record containing diagnostic and demographic resident information), the admission Record indicated the facility admitted Resident 1 on 9/14/2011 and readmitted Resident 1 on 12/21/2025 with diagnoses including dementia (a loss of mental ability that affects memory, thinking, and behavior to the point that it interferes with daily life). During a review of Resident 1's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 12/23/2025, the H&P indicated Resident 1 had capacity to understand and make decisions. During a review of Resident 1's follow-up psychiatric note dated 12/27/2025, the follow-up psychiatric note indicated Resident 1's diagnosis related to the use of Risperdal was schizoaffective disorder (a mental illness characterized by seeing or hearing things that are not there, paranoid delusions, and mood swings. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) assessment (a periodic comprehensive resident assessment performed by facility staff), dated 12/28/2025, Section I (active diagnoses) indicated Resident 1 did not have a diagnosis of schizophrenia, schizoaffective disorder, or bipolar disorder. During a review of Resident 1's Order Summary Report (a summary of all current physician orders) dated 1/22/2026, the Order Summary Report indicated Resident 1's attending physician prescribed Risperdal 1.5 milligrams (mg - a unit of measure for mass) by mouth one time a day for bipolar disorder (a mental illness characterized by extreme mood swings ranging for depressed lows to manic highs) manifested by throwing objects, fighting with staff on 12/22/2025. During a review of Resident 1's care plan related to the use of Risperdal, last revised 1/7/2026, indicated on 10/27/2022 Resident 1 was using Risperdal to treat a diagnosis of schizophrenia and was later updated on 12/11/2024 to bipolar disorder. During an interview on 1/22/2026 at 12:05 PM with the Director of Nursing (DON), the DON stated Resident 1's MDS dated [DATE] was inaccurate as the MDS did not indicate any of the psychiatric diagnoses included in Resident 1's clinical record related to the use of Risperdal. The DON stated failure to accurately assess Resident 1's challenges could result in care plans which were inadequate to address Resident 1's needs, possibly leading to a decline in his quality of life. During a review of the facility's policy titled RAI Process, revised 5/19/2025, the policy indicated All information recorded withing the MDS assessment must reflect the resident's status at the time of the Assessment Reference Date (ARD). b. During a review of Resident 69's admission Record, the admission Record indicated the facility admitted Resident 69 on 4/9/2025 with diagnoses including schizophrenia (a mental illness characterized by hearing or seeing things that are not there). During a review of Resident 69's H&P dated 4/10/2025, the H&P indicated Resident 69 had capacity to understand and make medical decisions. During a review of Resident 69's MDS assessment Section I dated 10/14/2025, the MDS Section I indicated Resident 69 did not have a diagnosis of depression. During a review of Resident 69's care plan related to the use of sertraline last revised 1/18/2026, the care plain indicated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 69 used sertraline related to depression manifested by excessive crying for her husband. During a review of Resident 69's Order Summary Report dated 1/22/2026, the Order Summary indicated Resident 69's attending physician prescribed sertraline (a medication used to treat depression) 25 mg by mouth one time a day for depression manifested by uncontrollable crying for husband. During an interview on 1/22/2026 at 11:52 AM with the DON, the DON stated Resident 69's MDS assessment dated [DATE] was inaccurate as it omitted a diagnosis of depression despite evidence of treatment for depression in Resident 69's clinical record. The DON stated failing to complete resident assessments correctly, including all information available in the medical record, could lead to care plans which don't adequately address a resident's needs possibly leading to an inability to reach their highest practicable level of functioning (in general).

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a Pre-admission Screening and Resident Review (PASRR - a federal requirement ensuring people with mental illness, intellectual disabilities, or related conditions are not inappropriately placed in nursing homes) was done for one of five sampled residents (Resident 42) diagnosed with a mental illness prior to admission in the facility. This failure had the potential for Resident 42 not to receive the necessary and appropriate psychiatric evaluation (is a comprehensive mental health assessment by a professional to diagnose emotional, behavioral, or cognitive conditions, guide treatment, and understand a person's overall mental state) and level of treatment at the facility.Findings: During a review of Resident 42's admission Record, the admission Record indicated the facility admitted Resident 42 on 8/18/2025 with diagnoses that included end stage renal disease (ESRD - irreversible kidney failure), essential (primary) hypertension (HTN - high blood pressure), hyperlipidemia (too much fat such as cholesterol in the blood), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool) dated 11/25/2025, the MDS indicated Resident 42 had the ability to make himself understood and had the ability to understand others. During a concurrent interview and record review on 1/21/2026 at 3:25 PM with the facility's Director of Nursing (DON), Resident 42's electronic medical record (EMR - a digital version of a patient's paper chart, storing health information like medical history, diagnoses, medications, and test results on a computer) was reviewed. The DON stated Resident 42 had a diagnosis of bipolar disorder and schizophrenia. The DON stated he (DON) could not locate Resident 42's PASRR in the EMR. During a concurrent interview and record review on 1/21/2026 at 3:25 PM with the facility's DON, the PASRR, DHS.CA.GOV website (a website where you can find PASRR information for someone) was reviewed. The DON logged onto the PASRR.DHR.CA.GOV website and stated he (DON) could not locate a PASRR for Resident 42. During a concurrent interview and record review 1/21/2026 at 3:25 PM with the facility's DON the facility's policy and procedure (P&P) titled Pre-admission Screening and Resident Review (PASRR), dated 2/17/2025 was reviewed. The P&P indicated I. All individuals, regardless of payer source, seeking admission to a Medi-Cal-certified SNF (Skilled Nursing Facility) must have a PASRR Determination by the Department of Health Care Services (DHCS - a state agency that manages and funds health programs for low-income residents, primarily operating Medi-Ca) or Department of Development Services (DDS- a state agency that helps Californians with developmental disabilities [such as autism, epilepsy, cerebral palsy, and intellectual disabilities] live independent, productive lives) prior to the Facility accepting the admission. II. The Facility ensures that PASRR Level I (a mandatory, quick, initial screening for anyone entering a Medicaid-certified nursing home to check for mental illness, intellectual disabilities or related developmental conditions) is completed either by the transferring general acute care hospital [GACH - a facility providing 24/7, short-term, in-patient care for severe, sudden, or urgent health conditions] or by the Facility for all applicants, regardless of payor, prior to admission to determine if they have a serious mental illness (SMI) and/or intellectual disability (ID -significant limitations in both mental functioning and adaptive skills needed for daily life, such as communication and self-care), developmental disability (DD - a lifelong condition, appearing before age [AGE], that affects a person's physical, learning, language, or behavior areas) or related condition(s) (ID/DD/RC). A. All potential resident of the Facility, whether or not they receive or are eligible for Medical, receive the Level I screening.III. The Facility also (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducts PASRR Level I screening for current residents who have a mental illness or intellectual disability and experience a significant change in their condition based on MOS 3.0 guidelines.IV. A negative PASRR Level I screen permits admission to proceed and ends the PASRR process unless a possible SMI or ID/DD/RC arises later. A positive PASRR Level I screen necessitates an in-depth evaluation of the individual by a Level II Contractor, known as PASRR Level II (an in-depth, personalized assessment conducted when a preliminary screen [Level 1] suggests a nursing home applicant has a mental illness or intellectual disability, which must be conducted prior to admission.The DON stated there was no proof of a PASRR was done for Resident 42. The DON stated the facility would not be able to properly treat Resident 42's mental health conditions without performing a PASRR. During an interview on 1/23/2026 at 10:50 AM with the facility's Administrator (ADM), the ADM stated she (ADM) would investigate to see if Resident 42 had a PASRR performed by the general acute care hospital (GACH) before transferring the facility. The ADM was not able to provide proof Resident 42 had a PASRR.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to develop an individualized person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) to meet the resident's needs for two of sixteen sampled residents (Resident 54, and Resident 69), by failing to: 1. Create and implement an at risk for falls care plan for Resident 54 on 11/11/25 after the resident suffered a fall.2. Create and implement a care plan for Resident 69 requiring supervision or touch assistance with meals.3. Create and implement a care plan for Resident 69's specific behaviors defined as aggressive or disruptive related to the use of Depakote (a prescription medication used as a mood stabilizer) and Risperdal (a prescription antipsychotic medication used to treat serious mental health conditions). These failures had the potential for Resident 9, Resident 54, and Resident 69 to receive inadequate care and for Resident 69 activities associated with mental processes and behavior) increased the risk that Resident 69 could have experienced adverse effects (unwanted or dangerous medication-related side effects) related to psychotropic medication (medications that affect brain activities associated with mental processes and behavior), possibly leading to a decline in her quality of lifeFindings: 1.During a review of Resident 54's admission Record, the admission Record indicated the facility re-admitted the resident on 11/09/2025 with diagnoses that included lack of coordination (poor muscle control that causes clumsy movements), muscle weakness, cognitive communication deficit (an impairment in communication caused by the disrupted ability to think, understand, reason, and remember), other abnormalities of gait (the pattern of walking) and mobility (movement), and dementia (a progressive state of decline in mental abilities). During a review of Resident 54's Fall Risk Assessment (a standardized questionnaire test used by healthcare professionals to evaluate and score an individual's likelihood of falling) dated 11/11/2025, the Fall Risk Assessment indicated Resident 54 had a fall risk score of 80 and was at high risk of falling (a score of 45 and higher indicated there was a high risk of falls). The Fall Risk Assessment indicated Resident 5 had fallen before, had more than one diagnosis on his chart, used crutches, a cane, or a walker, had a weak gait (balance), and overestimated or forgot his limits. During a review of Resident 54's Change in Condition Evaluation dated 11/11/2025, the Change in Condition Evaluation indicated the resident had a fall. The Change in Condition Evaluation indicated staff had witnessed Resident 54 in the hallways bending over from a standing position, raised his head up, the resident lost his balance, fell on his bottom, and hit his back on the closed door. The Change in Condition Evaluation indicated Resident 54 complained of mild pain to the back and sacrum (tailbone area) after the fall. The Change in Condition Evaluation indicated Resident 54 did not have any obvious injuries. During a review of Resident 54's Minimum Data Set (MDS, a resident assessment tool) dated 12/19/2025, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 54 normally used a walker. The MDS indicated Resident 54 required partial/moderate assistance (helper does less than half the effort) for toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, personal hygiene, and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes the activity) for eating and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oral hygiene. During a review of Resident 54's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 54 had a fall risk score of 80 and was at high risk of falling (a score of 45 and higher indicated there was a high risk of falls). The Fall Risk Assessment indicated Resident 5 had fallen before, had more than one diagnosis on his chart, used crutches, a cane, or a walker, had a weak gait (balance), and overestimated or forgot his limits. During a review of Resident 54's Change in Condition (COC, a sudden clinically important decline from a patient's baseline in physical, cognitive, behavioral, or functional abilities) Evaluation dated 1/9/2026, the COC Evaluation indicated the resident had a fall. The COC Evaluation indicated Resident 54 had lost his balance and fell to his right side, landing on his right hip and leg. During a review of Resident 54's Care Plan Report revised 1/9/2026, the Care Plan Report indicated the resident had an actual fall on 11/11/2025 with minor injury due to poor balance and unsteady gait. The Care Plan Report indicated Resident 54 had another actual fall on 1/9/2026 with no injuries due to poor balance and unsteady gait. The Care Plan Report indicated a goal for Resident 54 was to resume usual activities without further incident through the review date. The Care Plan Report indicated interventions (specific actions the nursing staff takes to help a resident meet their health goals, like giving medication, repositioning them, or providing education, all detailed in their personalized care plan to ensure consistent, effective care) to continue the interventions on the at-risk plan; determine and address causative factors of the fall; monitor, document, and report as needed for 72 hours any signs and symptoms of pain, bruises, change in mental status, new onset of confusion, sleepiness, inability to maintain posture, and agitation to Resident 54's physician. During a review of Resident 54's Care Plan Report for all active care plans, the report indicated Resident 54 did not have a specific care plan for being at-risk for falls. During a concurrent interview and record review on 1/22/2026 at 12:26 PM with Licensed Vocational Nurse 3 (LVN 3), Resident 54's Care Plan Report revised 1/9/2026 was reviewed. LVN 3 stated Resident 54 had fallen on 11/11/2025 and 1/9/2026. LVN 3 stated Resident 54 had a care plan for the resident's actual fall on 11/11/2025 and 1/9/2026. LVN 3 stated Resident 54's actual fall care plan had an intervention to continue the interventions on the at-risk for falls care plan. LVN 3 stated and verified that Resident 54 did not have an at-risk for falls care plan. LVN 3 stated Resident 54 was at high risk of falling because the resident was forgetful, needed stand-by assistance (a form of care where a caregiver remains within arm's reach of an individual providing supervision and safety monitoring without offering direct physical aid unless needed) with walking, and the resident used a walker. LVN 3 stated Resident 54 should have had an at risk for falls care plan with interventions to educate Resident 54 to use the call light for assistance before getting out of bed, to have the resident wear non-skid socks, and to ensure the resident's room was clean and free of clutter. LVN 3 stated an at-risk for falls care plan was a guide that had interventions that the nurses (in general) used to monitor the residents and reduce the resident's chances of the falling again. LVN 3 stated if there was no at-risk for falls care plan there wouldn't be guidance for the nurses (in general) of what to do to prevent the resident from falling. LVN 3 stated if Resident 54 did not have an at-risk for fall care plan, there was a potential for the resident to fall again. During a concurrent interview and record review on 1/22/2026 at 2:02 PM with Registered Nurse 1 (RN 1), Resident 54's Care Plan Report revised 1/9/2026 was reviewed. RN 1 stated Resident 54 had a fall on 11/11/2025 and 1/9/2026. RN 1 stated Resident 54 had a care plan for his falls on 11/11/2025 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disease] has not been clearly identified) both eyes, unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance (acting out, agitated, aggressive or mood/personality changes), psychotic disturbance(hallucinations or strong delusions), mood disturbance (disruptive sadness, irritability), and anxiety (excessive worry, fear, and nervousness), other lack of coordination(the brain struggles to coordinate muscles, leading to jerky, unsteady, or inaccurate movements), dysphagia (difficulty swallowing), oral(mouth) phase and cognitive communication deficit (struggling with talking, listening, or understanding because of problems with thinking skills[cognition], rather than a physical speech or language issue). During a review of Resident 69's Minimum Data Set (MDS – a resident assessment tool) dated 10/14/2025, the MDS indicated Resident 69 had severely impaired vision (no vision or sees only light, colors or shapes; eyes do not appear to follow objects), did not use corrective lenses (contacts, glasses, or magnifying glass), had normal cognition (ability to think, understand, learn, and remember), had limitation in range of motion (ROM-the full distance and direction a joint[where two or more bones meet] can move, measured by how far it can bend, straighten, or twist) in the upper extremity(shoulder, elbow, wrist, hand) on one side and required supervision or touching assistance (helper provides verbal cues[short spoken words used as a guide] and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating . During a review of Resident 69's Optometry Exam Consult notes dated 8/13/2025, the notes indicated Resident 69 had vision loss in both eyes and had an inability to adapt to bifocals (eyeglasses with split into two parts to correct both far and near vision in one frame). The Optometry Exam Consult indicated Resident 69 had cataracts (a clouding of your eyes' natural lens, like looking through a foggy window, which makes vision blurry and hazy). During a review of Resident 69's Speech Therapy note dated 11/7/2025, the note indicated Resident 69 required set up and intermittent cues (occasional reminders) for identification location of food items on meal tray due to have been diagnosed of being legally blind (severe uncorrectable vision loss) and benefitted from verbal cues upon meal tray set up and also finger foods. During a review of Resident 69's Dietary Profile dated 1/13/2026, the dietary profile indicated Resident 69 was blind and was able to feed self with supervision and maximum assist. During an observation on 1/20/2026 at 12:55 PM, Resident 69 was observed in the dining room sitting in a wheelchair and eating lunch unassisted by staff. Resident 30 was observed sitting beside Resident 69 and intermittently was scooping up Resident 69's food into mounds on the plate and Resident 69 preceded to scoop up another spoonful of food to eat. Certified Nurse Assistant (CNA) 1 was observed sitting at the same table and was assisting another resident with their meal. During an interview on 1/20/2026 at 1:17 PM with Resident 69, Resident 69 stated I cannot see, I only see light in my eyes. I have cataracts in my eyes. I needed help but no other person had assisted me. During a concurrent interview and record review on 1/20/2026 at 1:23 PM, with Infection Preventionist (IP), Resident 69's Dietary Profile dated 1/13/2026 and complete Care Plan Report were reviewed. The IP stated any staff member that was in the dining area could have assisted Resident 69. The IP stated she did not have staff available to assist Resident 69 with eating. The IP stated she (IP) informed Resident 30 he could not help Resident 69 with her meals and he stopped. The IP stated Resident 69's Dietary Profile indicated Resident 69 required maximum assistance and supervision with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	eating. The IP stated and verified there was no care plan for Resident 69 requiring assistance with eating and there was not any documentation of Resident 69 refusing assistance with her meals. The IP stated if Resident 69 did not have a care plan, facility staff would not know how to take care of Resident 69 and the resident should have had a care plan, and a care plan was not created. During an interview on 1/20/2025 at 2:2 PM, with Certified Nurse Assistant (CNA)1, CNA 1stated and verified she did not assist Resident 69 and was sitting beside her but not assigned to assist the resident on that day (1/20/2025). CNA 1 stated Resident 69 could only see shadows. CNA 1 stated I saw the other resident helping her and he was not supposed to do that. During a concurrent interview and record review on 1/21/2026 at 12:21 PM, with Registered Nurse (RN) 1, Resident 69's complete care plan and the facility's policy and procedure (P&P) titled, Care Planning dated 2/17/2025 was reviewed. RN 1 stated Resident 69 could only see shadows and required verbal cues during meals for location of food. RN 1 stated and confirmed there was no care plan for Resident 69 needing supervision or touch assistance with meals. RN 1 stated any licensed nurse could have created a care plan. RN1 did not want to answer if the facility was following the policy on care planning. During a concurrent interview and record review on 1/21/2026 at 12:46 PM with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled, Care Planning dated 2/17/2025 was reviewed. The DON stated it was not appropriate for another resident to help Resident 69 with her meals. The DON stated staff should have assisted Resident 69 with her meal. The DON stated there was no care plan for Resident 69 requiring supervision or touch assistance with meals. The DON stated the consequence of not having had a care plan would have been not identifying Resident 69's needs to better help Resident 69. The DON stated any licensed nurse could have created a care plan. The DON stated the purpose of a care plan was to have interventions in place to address problems and have planned resident care with goals in mind. The DON stated the facility was not following policy on care planning since a care plan was not created for Resident 69's needs as indicated in the policy. During a review of the facility's policy and procedure (P&P) titled, Care Planning dated 2/17/2025, the P&P indicated A Licensed Nurse will initiate the Care Plan, and the plan will be finalized in accordance with OBRA/MDS guidelines. The P&P indicated Each Resident's Comprehensive Care Plan will describe the following: Services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. 3.A review of Resident 69's admission Record (a record containing diagnostic and demographic resident information), dated 1/22/26, the admission record indicated the resident was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness characterized by hearing or seeing things that are not there.) A review of Resident 69's History and Physical (H&P – a record of a physician's comprehensive medical assessment and plan) dated 4/10/25, the H&P indicated this resident had capacity to understand and make medical decisions. A review of Resident 69's Order Summary Report (a summary of all current physician orders), dated 1/22/26 indicated Resident 69's attending physician prescribed the following psychotropic medication therapy: 1. Depakote 750 milligrams (mg, unit of measurement) by mouth three times daily for schizophrenia (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manifested by aggressive behavior on 9/29/25. 2. Risperdal 2 mg by mouth twice a day for schizophrenia manifested by disruptive behavior on 4/9/25. A review of Resident 69's active care plans, last revised 1/15/26, indicated there were no care plans created to address Resident 69's disruptive behavior or aggressive behavior related to a diagnosis of schizophrenia. Further review of the available care plans indicated the care plans for the use of Risperdal and Depakote to treat aggressive behavior and disruptive behavior did not provide any specific examples of Resident 69's manifestations of the problematic behaviors, no individualized non-pharmacological approaches to address these behaviors, or any Resident-centered therapeutic goals for the reduction of these behaviors related to the use of psychotropic medications. During an interview on 1/22/26 at 11:52 AM with the Director of Nursing (DON), the DON stated the facility failed to care plan any specific behaviors defined as aggressive or disruptive related to the use of Depakote and Risperdal or any non-pharmacological interventions to address the problematic behaviors. The DON stated failure to care plan target behavior and non-pharmacological interventions could result in longer courses or higher doses of psychotropic medications possibly leading to a decline in the quality of life from medication adverse effects. A review of the facility's policy titled Psychotherapeutic Drug Management, revised 5/19/25, indicated The care plan will reflect an individualized team approach emphasizing person-centered interventions with measurable goals, timetables and specific interventions for the management of behavioral and psychological symptoms.

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F 0657 Level of Harm - Minimal harm or potential for actual 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 observation, interview, and record review, the facility failed to revise the care plans for three of 10 sampled residents (Resident 2, Resident 5, Resident 8) by failing to: -Ensure to revise(update) Resident 2's care plan for impaired cognition (having difficulties with thinking, learning, remembering, concentrating, solving problems, or making decisions) related to dementia (a progressive state of decline in mental abilities). -Ensure to revise Resident 5's care plan for falls. -Ensure to revise Resident 8's care plan for smoking. These failures had the potential to impact Resident 2's provision of care and services and placed Resident 5 and Resident 8 at risk for injuries related to falls and smoking. Findings: a. During a review of Resident 2's admission Record, the admission Record indicated the facility re-admitted Resident 2 on 1/29/2025 with diagnoses that included dementia (a progressive state of decline in mental abilities). During a review of Resident 2' Minimum Data Set (MDS, a resident assessment tool) dated 11/4/2025, the MDS indicated the resident had severe cognitive impairment (decreased ability to think, understand, and reason). The MDS indicated the resident was dependent (helper does all the effort) on help for eating, oral hygiene, toileting hygiene, showering/bathing himself, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 2's Care Plan Report dated 12/10/2025, the Care Plan Report indicated the resident had impaired cognitive function or impaired thought processes related to dementia. The Care Plan Report indicated goals for Resident 2 to be able to communicate basic needs on a daily basis, to maintain a current level of decision-making ability, and to remain oriented to person, place, situation, and time through the review date. The Care Plan Report indicated one intervention: Cognition: Resident is able to remember one/two/three instructions, find room, read, sit and participate in activities of choice. During a concurrent interview and record review on 1/22/2026 at 12:40 PM with Licensed Vocational Nurse 3 (LVN 3), Resident 2's Care Plan Report dated 12/10/2025 was reviewed. LVN 3 stated Resident 2 had a diagnosis of dementia. LVN 3 stated Resident 2 had a care plan for dementia, however, the care plan only had one intervention that indicated Cognition: Resident is able to remember one/two/three instructions, find room, read, sit and participate in activities of choice. LVN 3 stated Resident 2's care plan for dementia was not appropriate and was not personalized to the resident's needs for his diagnosis. LVN 3 stated Resident 2's care plan for dementia should be revised to include more interventions tailored to the resident's needs for dementia. LVN 3 stated Resident 2's care plan for dementia should include interventions such as establishing a routine for the resident, hanging a calendar in the resident's room, reminding him what day and date it was, bringing the resident out of his room to the activity room, encouraging the resident to do activities that he enjoys, and making the resident's environment familiar to him. LVN 3 stated the care plan helped the nurses (in general) monitor the resident. LVN 3 stated the care plan created interventions and guided the nurses (in general) on how to help the resident. LVN 3 stated that if Resident 2's care plan was not revised and personalized to meet the resident's needs for dementia there was potential for Resident 2 to not get the care he needed. During a concurrent interview and record review on 1/22/2026 at 2:15 PM with Registered Nurse 1 (RN (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1), Resident 2's Care Plan Report dated 12/10/2025 was reviewed. RN 1 stated Resident 2 had a diagnosis of dementia. RN 1 stated Resident 2 had a care plan for dementia; however, the care plan was not appropriate for the resident. RN 1 stated Resident 2's care plan for dementia only had one intervention that indicated Cognition: Resident is able to remember one/two/three instructions, find room, read, sit and participate in activities of choice. RN 1 stated Resident 2's care plan for dementia should be revised to include personal interventions such as making sure the resident was monitored for safety, ensuring to speak to the resident clearly, and ensuring the resident's environment was familiar with things he recognized. RN 1 stated it was important for Resident 2 to have a personalized care plan with interventions for the resident's diagnosis of dementia. RN 1 stated there was a potential for Resident 2 not to get the appropriate care for his dementia needs if the resident's care plan was not revised. RN 1 stated the nurses (in general) would not know what type of care and interventions to provide Resident 2 without a personalized care plan. During a concurrent interview and record review on 1/23/2026 at 10:16 AM with the Director of Nursing (DON), Resident 2's Care Plan Report dated 12/10/2025 was reviewed. The DON stated Resident 2 had a diagnosis of dementia. The DON stated Resident 2 had a care plan for dementia that had three goals and only one intervention that indicated Cognition: Resident is able to remember one/two/three instructions, find room, read, sit and participate in activities of choice. The DON stated Resident 2's care plan for dementia was not appropriate for the resident. The DON stated Resident 2's care plan for dementia should be revised to have personalized interventions, at least one intervention for each goal. The DON stated Resident 2's care plan should have interventions such as monitoring for changes in condition, activities, a neurology consult, monitoring for increased confusion, and labs. The DON stated if Resident 2's care plan was not appropriate and revised to include personalized interventions there was potential for the resident to receive inadequate care for his diagnosis of dementia. The DON stated the nurses (in general) would not know what kind of care to provide if there were not any interventions in place on Resident 2's care plan for dementia. During a review of the facility's Policy and Procedure (P&P) titled Management of Residents with Dementia dated 2/17/2025, the P&P indicated The care plan will reflect an individualized team approach emphasizing person-centered interventions with measurable goals, timetables and specific interventions for the management of behavioral and psychological symptoms.The Care Plan will include the problem/symptoms the resident is experiencing, goals for the resident, a sticker or note describing the side effects of the drug, non-pharmacologic interventions to help the resident cope with the problem i.e., quiet environment, comfort items nearby, frequent supportive visits by staff etc. Interventions by nursing, activities, social services, and other departments as indicated will also be included on the care plan. During a review of the facility's P&P titled Care Planning dated 2/17/2025, the P&P indicated Purpose: To ensure that a comprehensive person-centered Care Plan is developed for each resident based on their individual assessed needs.A Comprehensive Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. Each resident's Comprehensive Care Plan will describe the following: services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; any services that would be required, but are not provided due to the resident's exercise of rights, which includes the right to refuse treatment; any specialized services including rehabilitative service as a result of PASARR recommendations. If the facility disagrees with PASARR findings, rationale will be notated in the resident's medical record; the resident's goals for admission and desired outcomes; and discharge plans as appropriate.The IDT will revise the Comprehensive Care Plan as needed (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that included hereditary idiopathic neuropathy (a group of different inherited medical conditions that cause nerve damage, pain, numbness, tingling, or weakness usually in the hands or feet), diabetes type 2 s (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with polyneuropathy (nerves throughout the body are damaged, causing weakness, numbness, tingling, and pain, usually starting in the feet and hands and often occurring symmetrically on both sides), lack of coordination, reduced mobility (move around), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 8's History and Physical (H&P) dated 12/27/2025, the H&P indicated Resident 8 had contractures of both hands (a condition where tissue in the palm tightens, thickens, and scars, causing one or more fingers to curl permanently toward the palm making it difficult to grip, hold, or pick up objects, and creates challenges for tasks like putting hands in pockets or washing faces) and needed assistance with personal care (non-medical, hands-on assistance with daily tasks such as bathing, brushing teeth, hair and skin care, and shaving). The H&P indicated Resident 8 had the capacity (ability) to understand and make decisions. The H&P indicated Resident 8 was a smoker. During a review of Resident 8's Nursing admission Assessment 5.5, dated 12/2025 at 8:20 PM, the Nursing admission Assessment 5.5 indicated Resident 8 required supervision for smoking. The Nursing admission Assessment 5.5 box marked Resident currently smokes and is able to hold physical the smoking device while smoking was not checked indicated Resident 8 could not hold a smoking device. The Nursing admission Assessment 5.5 box marked Resident can light and smoke cigarette or other smoking device while demonstrating safe technique or putting out matches or lights and disposing ashes was not checked indicated Resident 8 could not smoke safely or dispose of ashes. The Nursing admission Assessment 5.5 indicated the box marked Resident is a safe smoker and can perform function independently was not checked indicated Resident 8 was not an independent smoking (able to smoke without supervision). During a review of Resident 8's Minimum Data Set (MDS – a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 8 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 8 was dependent (helper does all of the effort and resident does none of the effort to complete activity) for upper and lower body dressing, for personal hygiene (comb hair, shaving, washing/drying face and hands) and for toileting. During a review of Resident 8's Care Plan titled At risk for injury related to smoking, dated 1/2/2026 indicated an intervention for Smoking apron offered during smoking time, respect residents preference and an intervention for Supervised smoking at all times. During a review of Resident 8's Physician Progress Notes dated 1/7/2025, the Physician Progress Notes indicated Resident 8 had decreased functional capacity (a measure of what a person can physically and mentally do in their daily life), fluctuating cognitive capacity (a person's practical ability to use their thinking skills like memory, focus, planning, and judgment to manage everyday tasks independently), and coordination deficits (a person has difficulty making smooth, precise, and purposeful body movements). During a review of Resident 8's Progress Notes dated 1/1/2026 to 1/20/2026, the Progress Notes indicated no documentation the facility offered Resident 8 a smoking apron (a fire-resistant protective cover worn over the chest and lap, primarily for wheelchair users or bedridden individuals to act as a safety shield to catch falling ashes to prevent burns to clothing, skin, or furniture). The Progress Nites indicate there was no documentation that Resident 8 refused a smoking apron. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 1/20/2026 at 10:31 AM with Certified Nursing Assistant 1 (CNA 1) in the facility's designated smoking area, Resident 8 was observed smoking without a smoking apron using his contracted hand/fingers to wipe away excess ashes from his cigarettes with the ashes falling directly on Resident 8. CNA 1 stated he (CNA 1) would only offer a smoking apron if a resident (in general) could not independently smoke. During a concurrent observation and interview on 1/20/2026 at 10:38 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 8 was observed smoking without a smoking apron. LVN 3 stated Resident 8 could burn himself if he could not hold his (Resident 8) cigarette safely with his (Resident 8) contracted hands/fingers. LVN 3 stated Resident 8 would also be at risk for burning himself if Resident 8 used his (Resident 8) fingers to remove excess ash from his (Resident 8) cigarette and allow the ash to fall on himself (Resident 8) without a smoking apron. LVN 3 stated if Resident 8 refused to use a smoking apron, the facility would need to document the refusal to follow his (Resident 8) individualized person-centered care plan (customized roadmap for support built specifically around a person's unique needs, goals, and preferences). During a concurrent interview and record review on 1/20/2026 with the Social Services Director (SSD), Resident 8's Smoking assessment dated [DATE] was reviewed. The Smoking Assessment indicated Resident 8 was not an independent smoker and required supervision. The SSD stated it was recommended for Resident 8 to use a smoking apron. The SSD stated if Resident 8 did not use a smoking apron, the ashes from Resident 8's cigarette could fall on him (Resident 8) and cause a burn. The SSD stated she (SSD) or the licensed nurses would have been responsible for creating a smoking care plan for Resident 8. During a concurrent interview and record review on 1/22/2026 at 8:16 AM with Registered Nurse 1 (RN 1) and LVN 3, Resident 8's Progress Notes dated 1/1/2026 to 1/22/2026 were reviewed. LVN 3 stated there was no documentation of the facility offering Resident 8 a smoking apron or documentation Resident 8 was using his fingers to wipe the excess ashes from his (Resident 8) cigarette (reference observation and interview on 1/20/2026 at 10:31 AM with CNA 1). LVN 3 stated CNA 1 did not report any issues with Resident 1's smoking/ashes on himself (Resident 8) on 1/20/2026 or she (LVN3) would have documented Resident 8's smoking issues and refusal to use a smoking apron. RN 1 stated Resident 8 could have had an injury if Resident 8 was allowed to have ashes fall on him (Resident 8) without a smoking apron on. RN 1 and LVN 3 stated the facility did not document any interventions from Resident 8's smoking care plan. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the Director of Nursing (DON), Resident 8's Smoking assessment dated [DATE] was review. The Smoking Assessment indicated the question Resident can light and smoke a cigarette or other smoking device while demonstrating safe technique or putting out matches or lights and disposing ash was not checked. The DON stated Resident 8 was not able to safely dispose of cigarette ashes according to the Smoking Assessment. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the DON, Resident 8's Care Plan titled At risk for related to smoking dated 1/2/2026 and Progress Notes dated 12/23/2025 to 1/22/2026 were reviewed. The DON stated there was no indication that the staff (unidentified) documented any interventions from Resident 8's care plan. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the DON, the facility's policy and procedure (P&P) titled, Smoking, dated 2/17/2025 was reviewed. The P&P indicated the following sections: B. If necessary, a referral to PT (physical therapy - helps you move better, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reduce pain, and get back to your daily activities after an injury, surgery, or illness by using movement, exercise, and hands-on care, acting like a movement doctor to fix problems with your muscles, joints, and balance so you can live more independently and confidently) /OT (occupational therapy - helps people do the everyday activities they need and want to do, like getting dressed, cooking, working, or playing, when an illness, injury, disability, or developmental challenge makes it hard for them) to assess for the necessary eye-hand coordination and cognitive skills (the brain's core tools used to think, learn, remember, pay attention, and solve problems) for safe smoking may be required. IX. Residents who smoke shall wear a smoking apron if they are found not to be safe (i.e., drop lit cigarettes or do not handle the ashes properly). During an interview on 1/22/2026 at 9:30 AM with the DON, the DON stated he (DON) could not find a PT/OT evaluation for Resident 8's smoking. During an interview on 1/22/2026 with the facility's Administrator (ADM), the ADM stated the facility did not refer Resident 8 for a PT/OT evaluation to assess Resident 8's necessary eye-hand coordination and cognitive skills per the facility's policy. The ADM stated the PT/OT evaluation was not done. During a review of the facility's policy and procedure titled, Smoking, dated 2/17/2026, the P&P indicated the purposed of the policy was To respect resident/employee choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. The P&P indicated The Facility discourages smoking by residents and ensures that those residents who choose to smoke do so safely. The P&P indicated Residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas. The P&P indicated Residents who are not able to smoke independently and safely will be accompanied by Facility Staff while smoking. The P&P indicated Residents who smoke shall wear a smoking apron if they are found not to be safe (i.e., drop lit cigarettes or do not handle the ashes properly.) If clothing is found to have cigarette burn holes the smoker must wear an apron to protect themselves from burns regardless of whether the resident is assessed as independent for smoking.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 79) reviewed for skin care received the care required to prevent pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to: -Ensure to set Resident 79's low air loss mattress (LALM - a medical bed surface designed for immobile patients to prevent or treat bedsores) according to Resident 79's weight. This failure had the potential for Resident 79 to develop pressure injuries and/or worsen skin wounds (injury that break the skin or other body tissues).Findings: During a review of Resident 79's admission Record, the admission Record indicated the facility originally admitted Resident 79 on 1/22/2019 and readmitted Resident 79 on 1/15/2026 with diagnoses that included cerebral palsy (a lifelong condition that leads to problems with movement, balance, and posture, like a broken communication line between the brain and muscles), type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified protein-calorie malnutrition (a person is not getting enough food, specifically protein and total calories, to keep their body functioning properly, but the exact cause or specific type is not defined), unspecified intellectual disabilities (a condition that limits intelligence and disrupts abilities necessary for living independently), unspecified convulsions (sudden, involuntary muscle spasms, shaking, or rigid body movements lasting seconds to minutes, where the exact cause or specific type is not immediately determined), heart failure (your heart isn't pumping as well as it should, failing to deliver enough oxygen-rich blood to meet the body's needs, causing fatigue, shortness of breath, and fluid buildup), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool) dated 12/25/2025, the MDS indicated rarely/never could make himself (Resident 79) understood and rarely/never had the ability to understand others. The MDS indicated Resident 79 was dependent (helper does all of the effort and resident does none of the effort to complete activity) for oral hygiene (clean teeth), toileting, showering/bathing, upper/lower body dressing, personal hygiene (comb hair, shaving, washing/drying face and hands), rolling to the left, rolling to the right, moving from sitting to lying position transferring from chair to bed, and going to the toilet. During a review of Resident 79's Dietary Profile, dated 1/16/2026, the Dietary Profile indicated Resident 79 weighed 79 pounds. During a review of Resident 79's Progress Note dated 1/16/2026 at 3:48 PM, the Progress Note indicated Resident 79 had a left middle back surgical wound measuring 12 centimeters (cm a unit of measurement) x 18 cm x utd (undetermined). The Progress Note indicated Resident 79's skin was fragile. During a review of Resident 79's History and Physical (H&P), dated 1/18/2026, the H&P indicated Resident 79 did not have the capacity (ability) to understand and make decisions). The H&P indicated Resident 79 had a large ulcer (a small open sore or wound generally found in the stomach or on the skin) upper back. The H&P indicated Resident 70 had stiffness and contraction (permanent tightening or shortening of muscles, tendons, or skin, causing joints to become stiff, bent, and fixed in one position) on his (Resident 79) back and extremities. During a concurrent observation, and interview on 1/20/2026 at 11:31 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 79's LALM was observed to be set for a weight between 300 and 350 pounds. LVN 3 stated the LVNs (in general) were responsible for checking to ensure the LALM settings were set correctly. LVN 3 stated Resident 79's LALM weight setting was set too high. LVN 3 stated Resident 79's back wound could get worse if the LALM was set too high. LVN 3 stated the LALM should have been set according to Resident 79's weight. During a concurrent interview and record review on 1/20/2026 at 11:31 AM with LVN 3, Resident 79's electronic (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record (EMR - a digital version of a patient's paper chart, storing health information like medical history, diagnoses, medications, and test results on a computer) weight record dated 1/16/2026 was reviewed. LVN 3 stated Resident 79's weight was 79 pounds. During an interview on 1/20/2026 at 11:42 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 79's back wound could worsen if Resident 79's LALM weight setting was too high. RN 1 stated Resident 79's LALM settings should be set based on Resident 79's weight. During a review of Resident 79's Order Summary Report, dated 1/21/2026, the Order Summary Report indicated an order for Resident 79 to have a LALM for Resident 79's wound management. The LALM order indicated for the LAM to match Resident 79's weight. During an interview and record review on 1/23/2026 at 10:19 AM with the Director of Nursing (DON), the facility's user manual titled Med-Aire 8 (inch) Alternating Pressure Mattress Replacement System With Low Air Loss User Manual Item #14027 (undated), was reviewed. The user manual indicated The analog control unit (a method of managing devices using continuous, smooth, and variable signals like a [NAME] switch or volume knob) includes an easy-to-use dial that is adjustable to the patient's weight and comfort. The DON stated the facility's staff would not be able to tell what setting was comfortable for Resident 79 because Resident 79 could not verbalize (say) to staff what level setting on the LALM was comfortable. The DON stated the facility should have used Resident 79's weight for the LALM settings. The DON stated setting the LALM too high could make the LALM surface harder, increasing Resident 79's risk for pressure injury or could make Resident 79's back wound worse. During a review of the facility's user manual titled Med-Aire 8 Alternating Pressure Mattress Replacement System With Low Air Loss User Manual Item #14027 (undated), was reviewed. The user manual indicated the following: This analog control unit includes an easy-to-use pressure dial that is adjustable to the patient's weight and comfort.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident safety for two five sampled residents (Resident 8 and Resident 56) by failing to:-Ensure to implement safety smoking precautions for Resident 8. -Ensure to complete a post fall neurological assessment for the fall on 9/2025 and 12/2025 and Interdisciplinary Team (IDT- group of healthcare staff from different disciplines involved in the care of the resident), met, reviewed, and/or revised Resident 56's care plans after the fall on 09/10/2025 and 12/24/2025 to implement fall precautions for Resident 56. These failures had the potential for Resident 8 to have injuries related to unsafe smoking practices and for Resident 56 to sustain an injury from preventable fall.Findings: a. During a review of Resident 8's admission Record, the admission Record indicated the facility originally admitted Resident 8 on 5/19/2025 and readmitted Resident 8 on 12/26/2025 with diagnoses that included hereditary idiopathic neuropathy (a group of different inherited medical conditions that cause nerve damage, pain, numbness, tingling, or weakness usually in the hands or feet), diabetes type 2 s (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with polyneuropathy (nerves throughout the body are damaged, causing weakness, numbness, tingling, and pain, usually starting in the feet and hands and often occurring symmetrically on both sides), lack of coordination, reduced mobility (move around), and schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 8's History and Physical (H&P) dated 12/27/2025, the H&P indicated Resident 8 had contractures (a condition where tissue in the palm tightens, thickens, and scars, causing one or more fingers to curl permanently toward the palm making it difficult to grip, hold, or pick up objects, and creates challenges for tasks like putting hands in pockets or washing faces)of both hands and needed assistance with personal care (non-medical, hands-on assistance with daily tasks such as bathing, brushing teeth, hair and skin care, and shaving). The H&P indicated Resident 8 had the capacity (ability) to understand and make decisions. The H&P indicated Resident 8 was a smoker. During a review of Resident 8's Nursing admission Assessment 5.5, dated 12/2025 at 8:20 PM, the Nursing admission Assessment 5.5 indicated Resident 8 required supervision for smoking. The Nursing admission Assessment 5.5 box marked Resident currently smokes and is able to hold physical the smoking device while smoking was not checked indicated Resident 8 could not hold a smoking device. The Nursing admission Assessment 5.5 box marked Resident can light and smoke cigarette or other smoking device while demonstrating safe technique or putting out matches or lights and disposing ashes was not checked indicated Resident 8 could not smoke safely or dispose of ashes. The Nursing admission Assessment 5.5 indicated the box marked Resident is a safe smoker and can perform function independently was not checked indicated Resident 8 was not an independent smoking (able to smoke without supervision). During a review of Resident 8's Minimum Data Set (MDS – a resident assessment tool) dated 1/2/2026, the MDS indicated Resident 8 had the ability to make himself understood and had the ability to understand others. The MDS indicated Resident 8 was dependent (helper does all of the effort and resident does none of the effort to complete activity) for upper and lower body dressing, for personal hygiene (comb hair, shaving, washing/drying face and hands) and for toileting. During a review of Resident 8's Care Plan titled At risk for injury related to smoking dated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/2/2026, the Care Plan indicated an intervention for Smoking apron [a fire-resistant protective cover worn over the chest and lap, primarily for wheelchair users or bedridden individuals to act as a safety shield to catch falling ashes to prevent burns to clothing, skin, or furniture] offered during smoking time, respect residents preference and an intervention for Supervised smoking at all times. During a review of Resident 8's Physician Progress Notes dated 1/7/2025, the Physician Progress Notes indicated Resident 8 had decreased functional capacity (a measure of what a person can physically and mentally do in their daily life), fluctuating cognitive capacity (a person's practical ability to use their thinking skills like memory, focus, planning, and judgment to manage everyday tasks independently), and coordination deficits (a person has difficulty making smooth, precise, and purposeful body movements). During a review of Resident 8's Progress Notes dated 1/1/2026 to 1/20/2026, the Progress Notes indicated there was no documentation the facility offered Resident 8 a smoking apron. The Progress Notes indicated there was no documentation that Resident 8 refused a smoking apron. During a concurrent observation and interview on 1/20/2026 at 10:31 AM with Certified Nursing Assistant 1 (CNA 1) in the facility's designated smoking area, Resident 8 was observed smoking without a smoking apron using his contracted hand/fingers to wipe away excess ashes from his cigarettes with the ashes falling directly on Resident 8. CNA 1 stated he (CNA 1) would only offer a smoking apron if a resident (in general) could not independently smoke. During a concurrent observation and interview on 1/20/2026 at 10:38 AM with Licensed Vocational Nurse 3 (LVN 3), Resident 8 was observed smoking without a smoking apron. LVN 3 stated Resident 8 could burn himself if he could not hold his (Resident 8) cigarette safely with his (Resident 8) contracted hands/fingers. LVN 3 stated Resident 8 would also be at risk for burning himself if Resident 8 used his (Resident 8) fingers to remove excess ash from his (Resident 8) cigarette and allow the ash to fall on himself (Resident 8) without a smoking apron. LVN 3 stated if Resident 8 refused to use a smoking apron, the facility would need to document the refusal to follow his (Resident 8) individualized person-centered care plan (customized roadmap for support built specifically around a person's unique needs, goals, and preferences). During a concurrent interview and record review on 1/20/2026 with the Social Services Director (SSD), Resident 8's Smoking assessment dated [DATE] was reviewed. The SSD stated the Smoking Assessment indicated Resident 8 was not an independent smoker and required supervision. The SSD stated it was recommended for Resident 8 to use a smoking apron. The SSD stated if Resident 8 did not use a smoking apron, the ashes from Resident 8's cigarette could fall on him (Resident 8) and cause a burn. The SSD stated she (SSD) or the licensed nurses (in general) would have been responsible for creating a smoking care plan for Resident 8. During a concurrent interview and record review on 1/22/2026 at 8:16 AM with Registered Nurse 1 (RN 1) and LVN 3, Resident 8's Progress Notes dated 1/1/2026 to 1/22/2026 were reviewed. LVN 3 stated there was no documentation of the facility offering Resident 8 a smoking apron or documentation that Resident 8 was using his fingers to wipe the excess ash from his (Resident 8) cigarette (reference observation and interview on 1/20/2026 at 10:31 AM with CNA 1). LVN 3 stated CNA 1 did not report any issues with Resident 1's smoking/ashes on himself (Resident 8) on 1/20/2026 or she would have documented Resident 8's smoking issues and refusal to use a smoking apron. RN 1 stated Resident 8 could have had an injury if Resident 8 was allowed to have ashes fall on him (Resident 8) without a smoking (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	apron on. RN 1 and LVN 3 stated the facility did not document any interventions from Resident 8's smoking care plan. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the Director of Nursing (DON), Resident 8's Smoking assessment dated [DATE] was review. The DON stated the Smoking Assessment indicated the question Resident can light and smoke a cigarette or other smoking device while demonstrating safe technique or putting out matches or lights and disposing ash was not checked. The DON stated Resident 8 was not able to safely dispose of cigarette ashes according to the Smoking Assessment. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the DON, Resident 8's Care Plan titled At risk for related to smoking dated 1/2/2026 and Progress Notes dated 12/23/2025 to 1/22/2026 were reviewed. The DON stated there was no indication that the staff (in general) documented any interventions from Resident 8's care plan. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the DON, the facility's policy and procedure (P&P) titled, Smoking, dated 2/17/2025 was reviewed. The P&P indicated the following: B. If necessary, a referral to PT (physical therapy - helps you move better, reduce pain, and get back to your daily activities after an injury, surgery, or illness by using movement, exercise, and hands-on care, acting like a movement doctor to fix problems with your muscles, joints, and balance so you can live more independently and confidently) /OT (occupational therapy - helps people do the everyday activities they need and want to do, like getting dressed, cooking, working, or playing, when an illness, injury, disability, or developmental challenge makes it hard for them) to assess for the necessary eye-hand coordination and cognitive skills (the brain's core tools used to think, learn, remember, pay attention, and solve problems) for safe smoking may be required. IX. Residents who smoke shall wear a smoking apron if they are found not to be safe (i.e., drop lit cigarettes or do not handle the ashes properly.) XVI. Response to resident non-compliance with smoking rules include: A. First offense: A written letter issued to the resident and/or family regarding noncompliance (breaking rules or failing to follow instructions and safety procedures). B. Second offense: A written letter issued to the resident and/or family referencing the first offense letter and advising that a third offense results in the loss of smoking privileges. C. Third offense: A written letter Issued to the resident and/or family outlining the noncompliant behavior. At this time the resident loses their smoking privileges. D. Residents observed smoking following revocation of smoking privileges Is Issued a 30-day notice of discharge if their non-compliant behavior endangers other individuals (e.g. continuing to smoke in areas where oxygen is in use). The clinical/behavioral status of the resident endangering other individuals at the Facility will be documented by an associated physician in accordance with Policy No. - AD - 04 - Transfer and Discharge. During a concurrent interview and record review on 1/22/2026 at 8:22 AM with the DON, the DON (continued on next page)

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

stated he (DON) would need to investigate if Resident 8 had a PT/OT evaluation. The DON stated the facility did not give Resident 8 a noncompliance letter when Resident 8 did not comply with the facility's policy. The DON stated the facility was not following their Smoking policy.

During an interview on 1/22/2026 at 9:30 AM with the DON, the DON stated he (DON) could not find a PT/OT evaluation for Resident 8's smoking.

During an interview on 1/22/2026 with the facility's Administrator (ADM), the ADM stated the facility did not refer Resident 8 for a PT/OT evaluation to assess Resident 8's necessary eye-hand coordination and cognitive skills per the facility's policy. The ADM stated the PT/OT evaluation was not done.

During a review of the facility's policy and procedure titled, Smoking, dated 2/17/2026, the P&P indicated the purposed of the policy was To respect resident/employee choice to smoke and to maintain a safe healthy environment for both smokers and non-smokers. The P&P indicated The Facility discourages smoking by residents and ensures that those residents who choose to smoke do so safely. The P&P indicated Residents who want to smoke will be assessed for their ability to smoke safely prior to being allowed to smoke independently in these areas. The P&P indicated Residents who are not able to smoke independently and safely will be accompanied by Facility Staff while smoking.

2.During a review of Resident 56's admission Record, the admission record indicated Resident 56 was initially admitted to the facility on [DATE], with diagnoses including Huntington's disease (an inherited condition in which nerve cells in the brain break down over time), extrapyramidal and movement disorder (involuntary or uncontrollable body movements) and schizophrenia (a mental illness that is characterized by disturbances in thought).

During a review of Resident 56's Minimum Data Set (MDS – resident assessment tool) and care screening tool) dated 12/11/2025, MDS indicated that Resident 56's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was moderately impaired. MDS indicated Resident 56 required moderate to maximal assistance from staff for activities of daily living (ADLs – toileting hygiene, shower/bathing).

During a concurrent observation and interview of Resident 56 on 1/20/2026 at 1:11 p.m., Resident 56 observed awake, sitting in the wheelchair and unable to respond to questions.

During a review of Resident 56's records titled Progress notes dated 9/10/2025, Licensed Vocational Nurse 4 documented at around 11:48 a.m., Resident 56 was walking on the hallway without assistance, lost his balance and slowly fell on his buttocks. Resident 56 usually has unsteady gait/use wheelchair for locomotion. Noted with 2 small redness marks on the right mid lateral side of back area (1x2cm and 1x1.5cm).

During a review of Resident 56's records titled eINTERACT Change of Condition (COC) Evaluation dated 12/24/2025, COC indicated that Resident 56 had unwitnessed fall. Director of Nursing (DON) documented seen by staff and was able to help with assisting resident back up for assessment.

During a review of Resident 56's Care Plan (CP) Report titled falling star program initiated on 1/02/2026. CP interventions included: Assist resident to participate in activities. By joining activities, residents will be around staff for assistance. Encourage resident to use wheelchairs to move around the facility.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a subsequent review of Resident 56's Care Plan Report titled risk for falls initiated and revised on 11/26/2024. CP indicated goals that Resident 56 will be free of falls and minor/serious injury with interventions included: Anticipate and meet The resident's needs. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT as to causes. The resident needs a safe environment with: even floors free from spills and/or clutter; adequate, glare-free light; a working and reachable call light, the bed in low position at night, handrails on walls, personal items within reach. During a concurrent observation and interview with Certified Nursing Assistant 6 (CNA 6) on 1/20/2026 at 1:18 p.m., CNA 6 assisted Resident 56 back to bed and placed bed in lowest position. CNA 6 stated that Resident 56 is high-risk for fall and currently on falling star program. During a concurrent interview with Registered Nurse 1 (RN 1) and review of Resident 56's medical records, RN 1 stated that Resident 56 is non-verbal, has an unsteady gait, and is able to ambulate with assistance. RN 1 added that Resident 56 is at high risk for falls and is unable to use the call light. Staff rely on non-verbal cues such as restlessness, fidgeting, grimacing, and reaching for objects to identify needs. RN 1 explained that when a resident is assessed as high risk for falls, they receive an evaluation from a physical therapist and are placed on the Falling Star Program. This program includes interventions such as keeping the bed in a low position, using floor mats, performing frequent checks, and providing assistance during ambulation. RN 1 stated that according to the Change of Condition (COC) assessment, Resident 56 experienced falls on 09/10/2025 and 12/24/2025. RN 1 described the post-fall protocol as including a resident assessment, completion of a post-fall assessment, a 72-hour neurological assessment, updating the care plan, and notifying the physician and responsible party. RN 1 reported that for the fall on 09/10/2025, Resident 56 sustained minor injuries consisting of two small areas of redness on the right lateral side of the back. An X-ray of the right hip and pelvis was ordered but not completed because the resident refused. RN 1 indicated that there was no documentation of a post-fall assessment for the 12/24/2025 incident. RN 1 also stated that there are no 72-hour neurological assessment documentation for post fall on 9/10/2025 and 12/24/2025. RN 1 stated that the fall on 12/24/2025 might have been avoidable if staff had reviewed Resident 56's medications, provided physical therapy, and relocated the resident closer to the nurse's station following the 09/10/2025 fall. During a concurrent interview with the DON and a review of Resident 56's records on 1/22/26 at 1:40 p.m., DON stated the importance of conducting fall risk assessments to identify high-risk residents. DON added that assessments are done upon admission, quarterly, and within 24 hours post-fall. DON also stated that high-risk residents are placed in the Falling Star Program, which includes placing floor mats, bed in lowest positions, and providing frequent visual checks. DON stated that the nurses should have completed a 72-hour neurological assessment done post fall for Resident 56 but failed to do. DON stated an IDT, consisting of the resident, DON, family, and PT meets within three days after a COC. DON indicated that reassessment is crucial to continue identifying fall risks and adjusting interventions and medications. DON stated he failed to reassess Resident 56 on 12/24/2025. DON stated that there should be an update on Resident 56's care plan post fall on 12/24/2025. DON stated there is no documentation of IDT for post fall on 9/10/2025 and IDT was done on 1/2/2026 which is past three days from the fall on 12/24/2025. DON stated that he did not adhere to the policy of meeting with the IDT team. DON indicated the importance of the IDT discussing actions to prevent further falls, identifying the cause of the fall, and implementing patient-centered care. During a review of facility's Policy & Procedure (P&P) titled Fall Management Program revised on (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/17/2025, P&P indicated that strives to prevent resident falls through meaningful assessments, interventions, education, and reevaluation. During a review of facility's Policy & Procedure (P&P) titled Response to Falls revised on 2/17/2025, P&P indicated in the post fall assessment and monitoring, following each resident fall, the licensed Nurse will complete an incident report and perform a Post-Fall Assessment & Investigation. The licensed Nurse will also complete the Neurological Flow Sheet for any un-witnessed fall or witnessed fall with known head injury for 72 hours following the fall.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident received appropriate treatment and services to prevent urinary tract infections (UTI-an infection in any part of your urinary system, your kidneys, ureters, bladder and urethra) for one of two sampled resident (Resident 9) by failing to:1. Provide an on-going assessment of the use and removal of Resident 9's indwelling foley catheter (foley catheter - a hollow tube left implanted in a body canal or organ, especially the bladder, to promote drainage).2. Review and revise the individualized care plan when Resident 9 had UTI on 3/24/2025 and 09/15/2025.3. Initiate an interdisciplinary team (IDT) review when Resident 9 had UTI on 3/24/2025 and 09/15/2025 and a change of condition on 11/30/2025.These deficient practices has caused Resident 9 to develop catheter associated urinary tract infection (CAUTI - an infection of the urinary tract caused by a tube [urinary catheter] that has been placed to drain urine from the bladder [an organ inside the body that stores urine until it can be excreted]), pain and had potential to result in serious complications including sepsis (a potentially life-threatening complication of an infection).During a review of Resident 9's admission Record, the admission record indicated Resident 9 was initially admitted to the facility on [DATE], with diagnoses including type II diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis) with dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and benign prostatic hyperplasia (BPH - is a condition that occurs when the prostate gland enlarges, potentially slowing or blocking the urine stream). During a review of the Minimum Data Set (MDS - a resident assessment) dated 11/20/2025, MDS indicated that Resident 9's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated Resident 9 required maximal assistance from staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). The MDS also indicated that Resident 9 had an indwelling foley catheter. During a concurrent observation and interview with Resident 9 on 1/20/2026 at 10:50 a.m., Resident 9 had a foley catheter with yellow, cloudy urine noted in the tubing and started having it for over a year without knowing why. During an interview with LVN 4 on 1/21/2026 at 2:20 p.m., LVN 4 stated that there was no order for monitoring of urine output. LVN 4 stated that the urine had moderate amount and unable to answer amount in milliliter (ml- unit of measurement). During a review of Resident 9's laboratory urine culture resulted on 03/24/2025 indicated that Resident 9 had extended spectrum beta-lactamase (ESBL - an enzyme found in some strains of bacteria that can't be killed by many of the antibiotics that doctors use to treat infections) in the urine. During a review of Resident 9's records titled Surveillance Data Collection Form dated 3/25/2025, Infection Preventionist (IP) indicated that Resident 9 had Healthcare-Associated Infection (HAI) and was on contact isolation (separation of residents with an infection from residents without an infection) for ESBL in the urine. IP documented Resident 9 complained of pain around shaft of penis, foley in place, noted also with foul smell. Medical Doctor (MD) notified and ordered urinalysis with culture and sensitivity. Resident 9 continuous to have recurrent UTIs. During a review of Resident 9's records from General Acute Care Hospital 1 (GACH 1) on 9/13/2025, History and Physical (H&P) indicated that Resident 9 was admitted for a missed dialysis session and had a complicated urinary tract infection needing intravenous (IV -fluids given directly into the blood stream) antibiotics (medication (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	used to fight bacterial infection). The laboratory urinalysis result collected on 9/13/2025 indicated that white cells in urine (indicate an infection or inflammation within the urinary tract) had Too Numerous To Count (TNTC) and bacteria in urine had many. During a review of Resident 9's records titled Surveillance Data Collection Form dated 9/16/2025, IP documented that Resident 9 had Healthcare-Associated Infection (HAI) and was on Enhanced Barrier Precaution (an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs - bacteria that are resistant to more than one antibiotic and can cause serious infections in nursing facilities]). IP documented that Resident 9 reported pain around the shaft area, and Resident 9's catheter was found to be clogged. Resident 9 missed his dialysis appointment. Resident 9 was sent out and returned with a prescription for Ceftriaxone (an antibiotic used to treat a wide variety of severe bacterial infections) 1 gram (g-unit of measurement) IV daily for five days to treat a urinary tract infection (UTI). During a review of Resident 9's records titled eINTERACT Change in Condition (COC) Evaluation dated 11/30/2025, Registered Nurse 2 (RN 2) documented that Resident 9 was screaming in pain with rate of 8/10 in his private area and added, Resident 9 is noted to have urinary catheter, no urine output, rigid abdomen. RN 2 documented that Nurse Practitioner (NP) was notified and ordered to transfer Resident 9 to General Acute Care Hospital 2 (GACH 2). During a review of GACH 2 Resident 9's records titled ED Summary of Care dated 11/30/2025, records indicated the reason for the visit was difficulty urinating. Resident 9 received one dose of morphine sulfate (a drug used to treat moderate to severe pain) 4 milligram (mg-unit of measurement) IV. During a concurrent interview with Registered Nurse 1 (RN 1) and record review of Resident 9's medical records on 1/22/2026 at 08:40 a.m., RN 1 stated that according to assessment tab of Resident 9's medical records, there was a change of condition (COC) for Resident 9 related to foley catheter on 3/24/2025 and 11/30/2025. RN 1 added that there was no COC assessment initiated for Resident 9 when he was readmitted back on the facility on 9/15/2025 with prescription for antibiotics but only for monitoring for readmission. RN 1 stated there were no documented Interdisciplinary Team (IDT - a group of dedicated healthcare professionals who work to bring knowledge together to help residents receive the care they need) conference meeting for COC on 3/24/2025 and 11/30/2025. RN 1 added that there was an IDT documented on 9/16/2025 regarding readmission. During a review of Resident 9 records titled care conference IDT meeting, there were no documented records for COC on 3/24/2025 and 11/30/2025. During an interview with Infection Preventionist (IP) on 1/22/2026 at 12:09 p.m., IP stated responsibilities included monitoring foley catheter use, ensuring proper indications, and consulting urology when needed. IP added that foley catheters cannot remain indefinitely due to risks of infection and severe complications like sepsis (a life-threatening blood infection). IP stated that Resident 9 had two CAUTIs in 2025, linked to the use of a Foley catheter. IP also stated there was no documented care plan for educating Resident 9 on the catheter's indication. During a concurrent interview with Director of Nursing (DON) and record review of Resident 9's medical records on 1/21/2026 at 2:25 p.m., DON stated that Resident 9's foley catheter was initially inserted on 07/31/2024 and the facility has not attempted to remove the foley catheter. DON stated the physician order for foley catheter with an indication of obstructive bladder did not align with the facility's policy. DON stated that licensed nursing staff must monitor and evaluate the need for a foley catheter. DON stated, There should be a urology consultation for Resident 9. DON added that nurses are also responsible for following up with the doctor and arranging a urology consultation if necessary. DON stated that there are no records of Resident 9 having a urology consultation. During a review of facility's Policy & Procedure (P&P) titled Catheter-Care of revised on 2/17/2025 , P&P indicated that I. Each resident who is incontinent of urine is identified, assessed and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible; II. Residents who enter the Facility without an indwelling catheter will not be catheterized, unless the resident's clinical condition demonstrates that catheterization is necessary. A. An indwelling catheter is not used unless there is valid medical justification During a review of facility's Policy & Procedure (P&P) titled Care Planning revised on 2/17/2025, P&P indicated its purpose is to ensure a comprehensive, person-centered care plan is developed for each resident based on their assessed needs. I. The Facility's Interdisciplinary Team (IDT) will develop a Baseline and/or Comprehensive Care Plan for each resident in accordance with OBRA and MOS guidelines. A Comprehensive Care Plan will be developed for each resident. The Care Plan will include measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs.

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NAME OF PROVIDER OR SUPPLIER Alvarado Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1154 S.Alvarado St Los Angeles, CA 90006	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to administer five doses of Adderall (a medication used to treat mental illness) per the physician's order between 1/19/2026 and 1/21/2026 in one resident randomly sampled for medication errors (Resident 34). The deficient practice of failing to administer five doses of Resident 34's Adderall increased the risk that Resident 34 could have experienced medical complications from missing scheduled doses of her medication and caused Resident 34 to feel overwhelmed and anxious about the potential impact to her physical and mental health as a result or missing her medication. Findings:During an observation on 1/21/2026 at 11:19 AM of Station 1 Medication Cart, an empty bubble pack (unit dose packaging from the pharmacy containing individual doses of medication) for Resident 34's Adderall was observed in the locked compartment of the medication cart. During a review of Resident 34's Controlled Drug Record (a log for controlled drugs [medications with a high potential for abuse] indicating the time and date each dose was administered) for Adderall indicated the last dose from the empty bubble pack was administered to Resident 34 on 1/19/2026 at 2 PM. During a review of Resident 34's admission Record (a record containing diagnostic and demographic resident information), the admission Record indicated the facility admitted Resident 34 on 7/28/2025 and readmitted her on 1/6/2026 with diagnoses including major depressive disorder (a mental illness characterized by depressed mood, difficulty sleeping, and lack of energy and interest in usually enjoyable activities). During a review of Resident 34's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 1/6/2026, the H&P indicated Resident 34 also had a diagnosis of attention deficit hyperactivity disorder (ADHD - a neurological condition that affects how the brain manages focus, impulses, and energy levels.) Further review of the H&P indicated this resident did have the capacity to understand and make decisions. During a review of Resident 34's Order Summary Report (a summary of all current physician orders) dated 1/22/2026, the Order Summary Report indicated Resident 34's attending physician prescribed Adderall ER (Extended Release - a dosage form that releases the dose over a 24 hour period) 15 milligrams (mg - a unit of measurement for mass) to give two capsules by mouth two times a day for ADHD on 1/6/2026. During a review of Resident 34's Medication Administration Record (MAR - a record of all medications administered for a resident) dated January 2026, the MAR indicated Resident 34 missed (or received partial) doses of Adderall on 1/19/26, 1/20/2026, and 1/21/2026.A review of the corresponding nurse progress notes on the dates above indicated the following notes regarding the administration of Adderall:1/19/2026 at 9:12 AM - Refill requested from pharmacy.1/19/2026 at 1:48 PM - Gave resident half the dose.1/20/2026 at 7:59 AM - Out of stock. Awaiting pharmacy delivery.1/20/2026 at 2:56 PM - Out of stock. Awaiting authorization from pharmacy.1/21/2026 at 7:24 AM - Out of stock. Will follow up with pharmacy.1/21/2026 at 1:45 PM - Resident is out at appointment. During an observation and concurrent interview on 1/22/2026 at 9:08 AM of Station 1 Cart with Licensed Vocational Nurse 4(LVN 4), Resident 34's Adderall was observed to be available in the medication cart with the delivery manifest indicating delivery was made on 1/21/2026 at 7:39 PM. LVN 4 stated Resident 34's dose of Adderall from the afternoon of 1/21/2026 was missed not only because Resident 34 was out of the facility but also because the medication had not yet been delivered. LVN 4 stated the progress notes were incomplete and did not indicate that the medication was still out of stock at that time. During an interview on 1/22/2026 at 9:18 AM with the Director of Nursing, the DON stated there were administrative hurdles obtaining approval for the refill of Resident 34's Adderall. The DON stated refills should be requested at least three to five days in advance and possibly longer for controlled medications. The DON stated this time frame would allow the facility time to address any administrative hurdles in obtaining the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's refill to allow continuity of care for the resident's medications (in general). The DON stated that since the refill was requested on 1/19/2026, the same day Resident 34 received her last dose of medication, the facility failed to follow their policy regarding requesting refills sufficiently in advance. The DON stated this caused Resident 34 to miss five doses of her Adderall. The DON stated missing doses of psychotropic medications may cause medical or psychiatric complications resulting in an exacerbation of behaviors treated by the medication possibly leading to a decline in Resident 34's quality of life. During an interview on 1/22/2026 at 9:20 AM with Resident 34, Resident 34 stated she (Resident 34) only got half the dose of her Adderall on 1/19/2026 in the afternoon because that was all they (facility) had left. Resident 34 stated she (Resident 34) then missed two doses on 1/20/2026 and two doses on 1/21/2026. Resident 34 stated the facility routinely would delay her prescription refills with multiple medications, including her inhalers and other maintenance medications, to the point where she needed to sometimes take extra steps to manage obtaining her medications herself. Resident 34 stated having to manage her missing medications and thinking about the potential impact to her health causes her to feel overwhelmed and anxious.During a review of the facility's policy Medication Ordering and Receiving from Pharmacy revised January 2022, the policy indicated Reorder medication five days in advance of need to assure an adequate supply is on hand.During a review of the facility's policy Medication - Administration revised 2/17/2025, the policy indicated Medication will be administered by a licensed nurse per the order of an attending physician or licensed independent practitioner.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility failed to:1. Remove one expired insulin aspart pen (a medication used to control high blood sugar) affecting Resident 67 from the medication cart in one of two inspected medication carts (Station 1 Medication Cart). 2. Remove two vials of expired injectable lidocaine (a medication used to treat pain) and one vial of expired haloperidol (a medication used to treat mental illness) from the emergency kit (E-kit - a kit containing a limited supply of medication to be used on an emergency basis) in one of one inspected medication rooms (Medication Room). 3. Label one opened Arnuity Ellipta inhaler (a medication used to treat breathing problems) with an open date per the manufacturer's requirements affecting Resident 83 in one of two inspected medication carts (Station 2 Medication Cart). The deficient practices of failing to remove expired medications from the medication carts and E-kits and label open medication according to the manufacturer's requirements, increased the risk that Resident 67 and Resident 83 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death.Findings:During a concurrent observation and interview on 1/21/2026 at 11:19 AM of Station 1 Medication Cart with Licensed Vocational Nurse 4 (LVN 4), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One opened insulin aspart pen was found in the medication cart labeled with an open date of 12/16/2025. According to the product labeling, insulin aspart pens should be used or discarded withing 28 days of opening. During a concurrent interview, LVN 4 stated Resident 67's insulin aspart was expired. LVN 4 stated the open date was 12/16/2025 and it was only good for 28 days once opened. LVN 4 stated this should have been removed from the cart and replaced on the day it expired. LVN 4 stated administering insulin after expiration could cause it to be less effective at controlling high blood sugar which may ultimately lead to medical complications requiring hospitalization. During a concurrent observation and interview on 1/21/2026 at 11:31 AM of the Medication Room with LVN 4, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications:1. Two vials of injectable lidocaine were observed in the E-kit with a manufacturer's expiration date on 12/2025. 2. One vial of injectable haloperidol was observed in the E-kit with a manufacturer's expiration date of 12/2025. According to the product labeling, salmeterol/fluticasone inhalers should be used or discarded within one month of removal from the protective foil pouch. During a concurrent interview on 1/21/2026 at 11:31 AM, LVN 4 stated the lidocaine and haloperidol injectables from the E-kit expired last month. LVN 4 stated lidocaine was used to treat pain and if given when expired could be less effective at controlling pain that a resident might experience. LVN 4 stated that injectable haloperidol was usually used for behavioral control and if it was expired could cause a safety risk to an affected resident, other residents, or facility staff if it fails to help control behaviors. During a concurrent observation and interview on 1/21/2026 at 11:43 AM of Station 2 Medication Cart with LVN 3, the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications: 1. One opened Arnuity Ellipta inhaler was found without a labeled open date. According to the product labeling, Arnuity Ellipta inhalers should be used or discarded within six weeks of removing them from the protective foil pouch. During a concurrent (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview 1/21/2026 at 11:43 AM, LVN 3 stated the Arnuity Ellipta for Resident 83 was opened but not labeled with an open date. LVN 3 stated this inhaler expired six weeks after opening per the manufacturer's requirements and thus needs an open date to know when it would expire. LVN 3 stated this medication (Arnuity) was used to prevent breathing problems due to asthma and could cause Resident 83's asthma to worsen if it was given after expiration possibly leading to medical complications requiring hospitalization. During a review of the facility's policy titled Medication Storage in the Facility revised January 2025, the policy indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of according to procedures for medication disposal and reordered from the pharmacy if a current order exists.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to ensure the lunch menu was followed on 1/20/2026, when:1. One Dietary aide (DA2) did not communicate the allergies listed on two of three (the gluten free meal ticket [lists resident's food preferences, allergies, and the food items on the menu to be served and portions] and the lactose intolerant meal ticket) meal tickets.2. [NAME] 2 did not prepare the non-breaded plain hamburger patty replacement for the gluten free diets. As a result, the cooks served pureed country fried steak (breaded beef patty) containing gluten on a tray for a resident who was allergic to gluten, and potato gratin (sliced potatoes in creamy sauce) prepared with milk served on a tray for a resident who was lactose intolerant (milk intolerant). This deficient practice had the potential to result in decreased meal satisfaction, decreased caloric intake and residents experiencing symptoms associated with intolerance in two residents who had gluten intolerance and two residents who had lactose intolerance.Findings: A review of the facility lunch menu for the regular diet on 1/20/2026 indicated the following items would be served: Country fried steak (breaded beef patty); Au gratin Potatoes (sliced potatoes in creamy sauce); green beans, dinner roll/margarine; dessert and beverages. A review of the facility lunch menu for the Gluten free diet on 1/20/2026 indicated the following items would be served: hamburger; baked potatoes quarters; green beans, Gluten free bread/margarine; dessert and beverage A review of the facility lunch menu for the Lactose intolerance diet on 1/20/2026 indicated the following items would be served: same as regular but eliminate the potato au gratin. During the tray line (tray line-a system of food preparation, in which trays move along an assembly line) observation on 1/20/2026 at 12:30PM, the service of trays for residents who were on gluten free diet and lactose intolerance diet was observed. DA2 was observed not communicating the diet orders written on the meal during lunch service to the cooks serving the food. The meal ticket located on one tray indicated an order for a lactose intolerant diet to be served by eliminating the potato au gratin. The meal ticket on the tray with the for the gluten free pureed diet indicated a hamburger was to be served instead of country fried steak, and a baked potato instead of potato au gratin. During the same lunch service observation, the tray for gluten free and pureed texture received pureed country fried steak (breaded beef patty) with gravy and the tray for lactose intolerance received the potato au gratin. During a concurrent observation and interview with Dietary Supervisor (DS) on 1/20/2026 at 12:35PM, DS checked the meal carts before they left the kitchen. DS verified the cooks served the wrong food to residents on gluten free diet. DS stated DA2 did not follow the resident's preference list, diet orders, and menu when calling out the diets to be served. During an interview with Cook1 and Cook2 on 1/20/2026 at 12:40PM, Cook1 stated he did not prepare the hamburger for the gluten free diet per the menu. Cook1 stated facility did not have gluten free bread or dinner rolls. Cook2 stated the potato au gratin contained milk and one tray indicating lactose intolerance was served potato au gratin. Cook1 stated if the residents received the incorrect diet, they would have symptoms of the allergies and get sick. During an interview with DA2 on 1/20/2026 at 12:45PM, DA2 stated he was nervous and forgot to look at resident allergies and the food listed on the meal ticket. DA2 stated if residents received the wrong food, they could get sick. During a review of the facility's recipe titled Country Fried Steak (dated 2026) the recipe listed Allergens (triggers an allergic reaction in sensitive individuals) for: egg, gluten, soy, wheat. During a review of the facility's recipe titled Au Gratin Potatoes (dated 2026) the recipe listed allergens for: gluten, milk, soy and wheat. During a review of the ingredients listed on the gravy mix packaging, it indicated it contained wheat and gluten. During a review of the facility's diet manual titled (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lactose Controlled diet (dated 9/2025), the diet manual indicated, this diet is designed to reduce the symptoms of bloating, gas and diarrhea associated with consumption of lactose. Lactose intolerance is not an allergy. Foods that should be limited are milk and milk products During a review of the facility's diet manual titled Gluten Restricted Diet (dated 9/2025), the diet manual indicated, the diet aims to eliminate symptoms, such as diarrhea, weight loss, indigestion and bloating, caused by sensitivity to gluten. If a resident is admitted with a gluten allergy it is highly suggested, they are served this diet. Grains not allowed on a gluten restricted diet are wheat, flour, gravy etc. During a review of the facility policy titled Therapeutic Diets (dated 10/2023), the policy indicated dietary manager is responsible for ensuring, the correct type and amount of food is purchased to meet the needs of resident receiving therapeutic diets. During a review of the facility policy titled Menus (dated 10/2023), the policy indicated Food served should adhere to the written menu.When a substitution is requested, the substitute items should be compatible in nutritional value taking into consideration vitamins, minerals, and calories.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review, the facility failed to ensure: The minced and moist diet (diet for residents who experience biting, chewing or swallowing limitations. Food is soft and moist; the size of the lumps should be approximately 4 mm in size fits through gaps of fork prongs.) Au gratin potatoes (sliced potatoes in creamy sauce) were served in a form that was in accordance with the international Dysphagia Diet initiative (IDDSI - a framework made up of levels and describes food textures and drink thickness) Level Five (Minced and Moist foods) when breaded beef patties were chopped and not minced and the texture of the minced and moist was not small (minced) did not fit through the gaps of fork prongs and breaded beef patty was dry. This failure had the potential to result in meal dissatisfaction and increased choking risk for ten residents on the minced and moist diet.During an observation in the facility's kitchen on 1/20/2026 at 10:00AM, Cook1 removed a portion of baked breaded beef patties from the oven and placed them on a chopping board. Cook1 started cutting the baked breaded beef patties using a knife into pieces varying in size, some pieces of the beef were larger about 1 inch, and some were smaller. Cook1 stated that it was preparation for the minced and moist diet. Cook1 stated the baked breaded beef patties were chopped into small pieces and then would be served with gravy for moistness. Cook1 stated the kitchen staff did not use the food processor because it made the food mushy and sticky. During an observation of the tray line (tray line-a system of food preparation, in which trays move along an assembly line) service for lunch 1/20/2026 at 12:30PM, the minced and moist country fried steak looked dry and over cooked as the edges of the breading that covered the beef patty were brown; it was chopped into inconsistent size and not minced, there were some larger pieces of breaded patties and was not moist. During the serving of the minced and moist food observed the potato au gratin was not minced. During a concurrent interview with Dietary Supervisor (DS) and [NAME] 1 on 1/20/2026 at 12:30PM, Cook1 stated, the breaded patties were chopped and not minced, and Cook1 did not prepare minced and moist potato au gratin because the potato was already soft. Cook1 stated gravy would be added on top of the chopped patties during serving. During a concurrent observation and test tray (a process of tasting, temping [measuring the temperature of food to ensure it is safe to eat] and evaluating the quality of food) of the minced and moist country fried steak breaded beef patty and potato au gratin with DS, Cook1 and Cook2 on 1/20/2026 at 12:50PM, Cook1 stated the size of the food should have been very small. DS stated the food was supposed to fit through the gaps of the fork prongs. [NAME] 1 was asked to demonstrate the test to make sure the minced and moist food meets the specification of the minced and moist diet per the IDDSI guidelines. Cook1 stated kitchen staff used a fork to press on the food to make sure it was soft and fit between the gaps of the fork with no runny juices. Cook1 pressed on the Breaded patties with fork and then stated the patty piece was too large, not soft and the food did not fit between the prongs. Cook2 stated the cooks should have put the food in the food processor and pulse twice to achieve the minced consistency. Cook1 stated the pieces were also dry and needed to be mixed with gravy for moistness. DS stated it was important to follow the recipe for minced and moist diet because if the texture was not correct it could be a potential for choking and residents could end up in the hospital. During a review of the facility's recipe titled Country Fried Steak (dated 2026) the recipe indicated, Minced and Moist Level 5: Mince regular cooked portions. With no separate thin liquid prior to service (4mm, approximately 1/8th inch) use slot between fork prongs to determine whether minced pieces are correct size. Reheat to 165F. serve with gravy. During a review of the facility's recipe titled Au Gratin Potatoes (dated 2026) the recipe indicated, Minced and Moist Level 5: Mince regular cooked portions. With no separate thin liquid prior to service (4mm, (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	approximately 1/8th inch) use slot between fork prongs to determine whether minced pieces are correct size. Reheat to 165F. serve with gravy. During a review of the facility's diet manual titled Minced and Moist texture IDDSI Level 5 -MM5 (dated 9/2025), the diet manual indicated, the diet used to management of dysphagia with the food texture prepared as minced and moist; some people on this diet may be able to bit off a large piece of food but they are unable to chew it into small enough pieces that are safe to swallow. All recipes should be tested prior to service to ensure the texture and piece size meet the IDDSI guidelines. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 5 Minced and Moist is usually eaten with spoon or fork, for people who cannot bite off pieces of food safely but have some basic chewing ability. It is important that food is not sticky. You should be able to scoop food onto a fork, with no liquid dripping and no crumbles falling off the fork. Size of the food is 4mm, which is about the gap between the prongs of a standard dinner fork. Food testing method: Spoon tilt test and Fork drip test.

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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. Based on observation, interview and record review, the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when: 1.Clean and sanitized resident trays and cups were stored on the counter next to the handwashing sink and in the splash zone (the area within roughly 3 feet of a handwashing sink or drain, where water spray and particles from handwashing can contaminate surrounding surfaces). 2. The floor in the dry storage area located in the kitchen was not kept clean, food debris, a hair net, a lighter, condiments packages and plastic wrappers were on the floor. 3. Expired food was stored in the dry storage area. One unsealed bag of chocolate chips with no date, one bag of powder/ground graham crackers stored with the bag opened and received date of 8/30/2024 (expired), one container of Worcestershire sauce with a use by date (the final recommended date for safe consumption, indicates when food is at peak quality and should be treated as a safety deadline) of 3/21/2025, and one container of sesame oil with a use by date of 11/20/2025 (expired) were stored in the dry storage area. 4. Nutrition supplement/shakes labeled store frozen with manufactures instruction to use within 14 days of thawing, were not monitored for the date they were thawed to ensure expired shakes were discarded after this time frame. One box containing 30 single serving containers of chocolate flavored high calorie nutrition shakes were stored in the walk-in refrigerator with no thaw date. 10 single serving containers of vanilla flavored high calorie shakes were stored in the reach in refrigerator with no thaw date. This deficient practice had the potential to result in foodborne illness in 14 residents who receive nutritional shakes during lunch and snacks. 4. Food brought to residents from outside of the facility was stored in the resident's food refrigerator located in the nurse's station with no label and not monitored for the expiration date. There was one paper bag with open packages of deli meat (ham and bologna) and sliced cheese with no resident name; one subway sandwich dated 1/19/2026 and one bag of tamales and taco brought in on 1/19/2026 exceeding storage period for outside food; four yogurt smoothies with manufactures expiration dates of 10/11/2025 expired and stored in the resident refrigerator. These deficient practices had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to food borne illness in 62 out of 68 residents who received food from the facility and including residents who had food stored in the resident refrigerator.Findings: 1. During an observation in the facility's kitchen on 1/20/2026 at 8:20AM, resident food trays and cups were observed stored on the dish washing area counter and adjacent (next to) to the handwashing sink in the splash zone. During a concurrent observation and interview with Dietary Supervisor (DS) on 1/20/2026 at 8:30AM, DS verified that the trays and cups had been washed and stored on the counter to air dry. DS stated there was a potential to splash on the dishes next to the sink. During an interview with the Maintenance supervisor (MS) and DS on 1/20/2026 at 10:15AM, DS agreed that the dishes were in the splash zone and should have been covered to prevent cross contamination of the clean and sanitized dishes. MS stated there should have been a divider placed to prevent splashes on the clean dishes. During a review of the 2022 U.S. Food and Drug Administration Food Code, code 4-903.11 titled Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. code indicated, (A) cleaned EQUIPMENT and UTENSILS, laundered LINENS, and SINGLE-SERVICE and SINGLE-USE ARTICLES shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. 2. During a concurrent observation in the dry storage area of the facility's kitchen and interview on 1/20/2026 at 8:35AM, the floor behind the shelf was observed to be dirty with trash. Food debris, a hair net, a lighter, condiments packages and plastic wrappers were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056157	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Alvarado Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1154 S.Alvarado St Los Angeles, CA 90006	

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed on the floor. The DS stated there was trash on the floor. DS stated staff swept the floor every day. DS stated the floor had to be clean to prevent attracting pests. During a review of facility cleaning schedule and checklist dated January 2026, the cleaning schedule indicated weekly cleaning of the kitchen pantry. The schedule did not indicate cleaning the dry storage area. During the same observation and interview in the dry storage area on 1/20/2026 at 8:40AM, there was one unsealed bag of chocolate chips with no date, one bag of powder/ground graham crackers stored with the bag open and a received date of 8/30/2024 expired, one container of Worcestershire sauce with a use by date of 3/21/2025, and one container of sesame oil with a use by date of 11/20/2025 expired and stored in the dry storage area. During a concurrent observation and interview with DS on 1/20/2026 at 8:40AM, DS stated the powdered graham cracker was not used anymore and should have been discarded. DS verified the powdered graham cracker was expired and not sealed. The DS was then observed discarding the expired powdered graham cracker. DS stated the facility received a new shipment of chocolate chips for baking and then discarded the unsealed bag of chocolate chips with no date. DS stated once the bags were opened, they had to be dated and labeled then sealed tight to prevent cross contamination. DS stated all seasonings that were expired would be discarded. DS stated the bottle of oil and sauce had been at the facility for a long time. DS stated when seasonings were expired, they lost quality and taste. During a review of facility's policy titled Food storage (dated 10/1/23) the policy indicated, Dry storage guidelines: The walls, ceiling and floor should be maintained in good repair and regularly cleaned, any opened products should place in storage containers with tight fitting lids, label and date storage products and rotate stock. 3. During an observation in the kitchen on 1/20/2026 at 9:00AM, 30 single-serve cartons of chocolate flavored nutrition supplements/shakes stored inside the walk-in refrigerator with no date were observed. During a concurrent observation and interview with DS on 1/20/2026 at 9:00AM, DS stated the shakes were delivered frozen and they were stored in the freezer. DS did not know the expiration date of the nutrition shakes. The label on the nutritional shake indicated to store frozen and once thawed use within 14 days. The DS did not know when the nutritional shakes were removed from the freezer. During an observation of the kitchen's tray line refrigerator on 1/20/2026 at 9:15AM, 10 single serve cartons of vanilla flavored nutrition shake with no date were observed. DS did not know when the shakes were thawed. DS stated there should have been a date to monitor the thaw date. DS stated nutrition shakes were like milk and could go bad and cause residents to have stomach pain. 4. During an observation in the resident refrigerator located in the nurse's station on 1/21/2026 at 9:00AM, one paper bag with open packages of deli meat (ham and bologna) and sliced cheese with no label were observed stored in the resident refrigerator. One bag with a subway sandwich and one bag with a leftover taco and tamale with a date of 1/19/26 were observed stored in the resident refrigerator. Four expired yogurt smoothies with manufacturer expiration dates of 10/11/2025 were observed stored in the resident refrigerator. During a concurrent observation and interview with IP nurse on 1/21/2026 at 9:00AM; IP nurse stated residents families took food to the facility or the residents would order food from outside the facility. The IP stated leftovers were labeled with resident name and the date the food was brought in and then stored in the refrigerator for 72 hours. IP stated it was important to date, label, and discard items before they went bad. IP stated the yogurt smoothies were expired and should have been discarded because residents could get sick. During an interview with RN1 on 1/21/2026 at 9:30AM, RN1 stated nursing staff checked for expired items and discarded the items appropriately. RN1 verified the smoothies were expired and stated the smoothies should have been discarded. RN1 stated leftovers were stored for 72 hours but would confirm the policy and discard the food accordingly. RN1 stated outside food was monitored (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alvarado Care Center	1154 S.Alvarado St Los Angeles, CA 90006

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	before resident consumption to prevent risk of aspiration, choking and to discard any expired items. During a review of facility's policy titled Food Brought in by Visitors (dated 10/1/23), the policy indicated, Perishable food requiring refrigeration will be discard after two hours at bedside, and if refrigerated, it will be labeled, dated and discarded after 48hours.