STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eisenberg Village	18855 Victory Bl Reseda, CA 91335

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 44309 Based on interview and record review the facility failed to ensure the physician was notified of a resident's refusal of suprapubic catheter care for one of three sampled residents reviewed under the catheter care area. This deficient practice placed the resident at increased risk for infection. Cross reference F656 Findings: During a review of Resident 55's Admission Record, the Admission Record indicated the facility admitted the resident on 4/4/2023, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), retention of urine (a condition in which you are unable to empty all the urine from your bladder), and status post suprapubic catheter placement. During a review of Resident 55's Minimum Data Set (MDS -a resident assessment tool) dated 10/10/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 55 was dependent on staff (helper does all of the effort) for showering/bathing and required substantial/maximum assistance (helper does more than half the effort) for toileting hygiene, oral hygiene, personal hygiene, and upper and lower body dressing. The MDS further indicated that Resident 55 had suprapubic catheter. During a review of Resident 55`s Physician order dated 9/17/2024, the order indicated to clean the suprapubic catheter with normal saline (a saltwater solution), pat dry, apply A&D ointment (a medication used as a moisturizer to treat or prevent dry, rough, and itchy skin), and leave it open to air two times a day. During a review of Resident 55`s Treatment Administration Record (TAR) for November 10 to December 2, 2024, the TAR indicated that the resident refused to receive treatment to his suprapubic catheter surrounding skin on 12/2/2024, 11/30/2024, 11/28/2024, 11/22/2024, 11/16/2024 and 11/13/2024 during the 3 p.m.-11p.m. shift, and on 11/10/2024, 11/15/2024, 11/16/2024, 11/17/2024 and 11/23/2024 during the 7 a.m.-3 p.m. shift. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/3/2024 at 2:00 p.m., with the Director of Nursing (DON), Resident 55 `s TARs, nursing notes, and care plans were reviewed. The DON stated Resident 55 refused to receive treatment to his suprapubic catheter surrounding skin on 12/2/2024, 11/30/2024, 11/28/2024, 11/22/2024, 11/16/2024 and 11/13/2024 during the 3 p.m.-11p.m. shift and on 11/10/2024, 11/15/2024, 11/16/2024, 11/17/2024 and 11/23/2024 during the 7 a.m.-3 p.m. shift. The DON stated licensed staff were required to notify Resident 55`s physician of his refusal of treatment and care to his suprapubic catheter. The DON stated there is no documentation notifying Resident 55`s physician about his refusal of care. The DON stated the potential outcome of not informing a resident`s physician regarding his refusal of care and treatment is worsening of the resident`s condition due to lack of appropriate care During review of the facility`s Policy and Procedure (P&P) titled Indwelling Catheter Care, last revised 9/2024, the P&P indicated that a plan of care shall be developed and re-evaluated for the duration of the indwelling catheter use by nursing staff. The Plan of care should include indication for use, risk for infection and complications associated with use, and care plan for routine care and observation for signs and symptoms of complications such as infection. Resident response to treatment provided, physician communication regarding changes of condition should be documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47883 Based on observation, interview and record review, the facility failed to: 1. Develop a 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 the prevention of worsening a condition, and current treatments) addressing a resident's refusal to wear a mask while on contact/droplet precautions (steps that healthcare staff take to prevent the spread of germs when a patient has germs that can spread through touching and coughs and sneezes) for one (Resident 40) out of five sampled residents investigated during review of the infection control task. This deficient practice had the potential to delay the provision of necessary care and services to Resident 40. 2. Develop a care plan addressing the resident's refusal of care of his suprapubic indwelling catheter (a flexible plastic tube inserted into the bladder from a small cut in the stomach, that remains in place to provide continuous urinary drainage) and failed to implement a care plan intervention to monitor the resident`s urinary drainage bag for hematuria, checking the placement of the catheter and surrounding skin for signs of infection for one of three sampled residents reviewed under catheter care area. These deficient practices had the potential to result in the inadequate care and monitoring of Resident 55 and placed him at increased risk of infection. Cross reference F580 Findings: 1. During a review of Resident 40's Admission Record, the Admission Record indicated the facility originally admitted the resident on 5/1/2019 and readmitted the resident on 12/27/2023 with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), hyperlipidemia (condition where there is too much fat in the blood), and spondylosis (age related arthritis [abnormal wear on the cartilage and bones of vertebrae of the spine). During a review of Resident 40's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 11/07/2024, the MDS indicated the resident had severely impaired cognition (thought processes) and required moderate assistance from staff for most activities of daily living (ADLs - basic tasks that people do every day to survive and be well). During a review of Resident 40 Physician Order Report, the Physician Order Report indicated the following orders: 1. Contact/droplet isolation due to exposure to Respiratory Sinus Virus (RSV-common respiratory virus that infects the nose, throat, and lungs) from 11/20/2024 to 12/5/2024. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. May use mask when going out of the room from 11/20/2024-12/5/2024. During a concurrent observation and interview on 11/18/2024 at 11:49 a.m. with Certified Nursing Assistant (CNA 1), Resident 40 was observed without a mask outside her room in the common area and surrounded by other residents. CNA 1 stated Resident 40 was refusing to wear a mask or to stay in her room. During a concurrent interview and record review on 12/4/2024 at 12:01 p.m., with the Infection preventionist (IP), the IP reviewed Resident 40's care plans (a document that outlines a patient's health information, conditions, treatments, care services, and goals). The IP was asked if Resident 40 had a care plan addressing the resident's refusal of following contact/droplet precautions and wearing a mask when outside the room. LVN 2 stated she could not find any. During an interview on 2/5/2024 at 2:19 p.m., with the Director of Nursing (DON), the DON stated that when a resident refuses to follow the physician order, there should be a care plan for non-compliance. The DON stated if care plans were not in place, then the staff would not be able to address the resident's needs. During a review of the facility's policy and procedure titled, Care Plan, last reviewed and revised on 1/22/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental, and psychosocial needs shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. 44309 2. During a review of Resident 55's Admission Record, the Admission Record indicated the facility admitted the resident on 4/4/2023, with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), retention of urine (a condition in which you are unable to empty all the urine from your bladder), and status post suprapubic catheter placement. During a review of Resident 55's Minimum Data Set (MDS -a resident assessment tool) dated 10/10/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 55 was dependent on staff (helper does all of the effort) for showering/bathing and required substantial/maximum assistance (helper does more than half the effort) for toileting hygiene, oral hygiene, personal hygiene, and upper and lower body dressing. The MDS further indicated that Resident 55 had suprapubic catheter. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 55's Care Plan (CP-a document that outlines how a patient`s health care needs will be met) titled Alteration if Elimination: indwelling catheter related to neurogenic bladder and urinary retention, initiated on 11/10/2023, indicated a care plan goal that the resident will have a patent (open) indwelling catheter without sign and symptoms of infection. The care plan interventions were to empty the urinary drainage bag (a bag that collects urine from a catheter) every shift, offer fluids with meals, medication administrations, hydration passes, and bedside water, observe the urine output, observe for sign and symptoms of infection, monitor for hematuria (blood in the urine) in the urinary drainage bag, and check the placement of the catheter and surrounding skin for signs of infection during every shift. During a review of Resident 55`s Event Report dated 5/8/2024, the report indicated that the resident had redness surrounding his suprapubic catheter.  During a review of Resident 55`s Physician order dated 9/17/2024, the order indicated to clean the suprapubic catheter with normal saline (a saltwater solution), pat dry, apply A&D ointment (a medication used as a moisturizer to treat or prevent dry, rough, and itchy skin), and leave it open to air two times a day. During a review of Resident 55`s Treatment Administration Record (TAR) for November 10 to December 2, 2024, the TAR indicated that the resident refused to receive treatment to his suprapubic catheter surrounding skin on 12/2/2024, 11/30/2024, 11/28/2024, 11/22/2024, 11/16/2024 and 11/13/2024 during the 3 p.m.-11p.m. shift, and on 11/10/2024, 11/15/2024, 11/16/2024, 11/17/2024 and 11/23/2024 during the 7 a.m.-3 p.m. shift. During a concurrent interview and record review on 12/3/2024 at 2:00 p.m., with the Director of Nursing (DON), Resident 55 `s TARs, nursing notes, and care plans were reviewed. The DON stated Resident 55 refused to receive treatment to his suprapubic catheter surrounding skin on 12/2/2024, 11/30/2024, 11/28/2024, 11/22/2024, 11/16/2024 and 11/13/2024 during the 3 p.m.-11p.m. shift and on 11/10/2024, 11/15/2024, 11/16/2024, 11/17/2024 and 11/23/2024 during the 7 a.m.-3 p.m. shift. The DON stated licensed staff were required to notify Resident 55`s physician of his refusal of treatment and care to his suprapubic catheter. The DON stated there is no documentation notifying Resident 55`s physician about his refusal of care. The DON stated residents` care plans are required to be reviewed and revised quarterly and as needed and reflect the current person-centered interventions and care that are currently being delivered to the residents. During a concurrent interview and record review on 12/3/2024 at 2:33 p.m., with the MDS Coordinator (MDSC), Resident 55`s TARs and care plans were reviewed. The MDSC stated that she is in charge of initiating and revising residents` care plans. The MDSC stated residents' care plans are required to have the current and active nursing interventions for the residents. The MDSC further stated Resident 55`s TAR did not indicate any documentation regarding his care plan interventions such as monitoring the resident`s urinary drainage bag for hematuria, checking the placement of the catheter and surrounding skin for signs of infection. The MDSC stated there is no evidence that licensed nurses implemented these interventions. The MDSC stated all the resident`s care plan interventions are required to be implemented and the documentation is required to be available in the resident`s medical record. The MDSC stated the potential outcome of not updating resident`s care plans and not implementing the care plan interventions is lack of care to the resident that can potentially lead to infection and complications for the resident. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility`s Policy and Procedure (P&P) titled Indwelling Catheter Care, last revised 9/2024, the P&P indicated that a plan of care shall be developed and re-evaluated for the duration of the indwelling catheter use by nursing staff. The Plan of care should include indication for use, risk for infection and complications associated with use, and care plan for routine care and observation for signs and symptoms of complications such as infection. Resident response to treatment provided, physician communication regarding changes of condition should be documented in the medical record. During a review of the facility`s Policy and Procedure (P&P) titled Care Plans, last reviewed 1/22/2024, the P&P indicated that each resident`s comprehensive care plan has been designed to reflect treatment goals and objectives in measurable outcomes, build on the resident`s strengths, incorporate identified problem areas and incorporate risk factors associated with identified problems. Goals and objectives are reviewed and /or revised when there has been a significant change in the resident`s condition, when the desired outcome has not been achieved and when the resident has been readmitted to the facility from a hospital/rehabilitation stay and at least quarterly. Documentation must be consistent with the resident`s care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47883 Based on interview and record review, the facility failed to revise a care plan addressing the removal of indwelling urinary catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) for one (Resident 22) out of two sampled residents investigated during review of the catheter care area. This deficient practice had the potential to delay the provision of necessary care and services related to the resident's urinary catheter. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/25/2024 and readmitted the resident on 10/12/2024 with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection where the infection-fighting processes turn on the body, causing the organs to work poorly), and metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well). During a review of Resident 22's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 10/19/2024, the MDS indicated the resident had severely impaired cognition (thought processes) and required maximal assistance from staff for eating, oral hygiene, and upper body dressing. Further, the MDS indicated that Resident 22 was dependent on two or more helpers for toileting and personal hygiene, showering, and lower body dressing. During a review of Resident 22's Physician Order, dated 11/3/2024, the Physician Order indicated an order to discontinue the indwelling urinary catheter on 11/3/2024. During a concurrent observation and interview on 12/03/2024 at 2:34 p.m. in Resident 22 's room with Certified Nursing Assistant 3 (CNA 3), the surveyor observed CNA 3 wheeling Resident 22 out of the bathroom in a wheelchair. Surveyor did not observe any indwelling catheter attached to Resident 22. CNA 3 stated that Resident 22 used to have an indwelling catheter before, but it was discontinued. During a concurrent interview and record review on 12/03/2024 at 2:44 p.m., with Licensed Vocational Nurse 3 (LVN 3), reviewed Resident 22's care plans (a document that outlines a patient's health information, conditions, treatments, care services, and goals). LVN 3 stated Resident 22's care plan created on 10/14/2024, addressed the resident's risks of having an indwelling urinary catheter. LVN 3 stated that the indwelling catheter was discontinued 11/03/2024 and that the care plan should have been revised to ensure it is accurate and reflects Resident 22's current condition. During a concurrent interview and record review on 12/04/2024 at 9:26 a.m. with the Minimum Data Sheet Coordinator (MDSC), Resident 22's care plan for indwelling urinary catheter, dated 10/24/2024, was reviewed. The MDCS stated that the care plan was not revised when the medical device was removed. The MDCS stated that this deficient practice had the potential to delay the provision of necessary care and services to Resident 22. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/05/2024 at 2:19 p.m. with the Director of Nursing (DON), the DON stated that Resident 22's care plan for indwelling catheter had to be resolved after the catheter was removed to reflect Resident 22's assessment and current needs . During a review of the facility's policy and procedure titled, Care Plans, last reviewed on 1/22/2024, the policy indicated that an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychosocial needs shall be developed for each resident. The comprehensive care plan includes the services that are to be furnished to attain or maintain the resident's highest level of functioning. Care plans are revised as changes in the resident's condition dictate.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 47883 Based on observation, interview and record review, the facility failed to ensure a resident was provided a communication device with the language that the resident is able to understand for one of one sample resident (Resident 22) investigated under the communication care area. This deficient practice prevented the resident from communicating with the staff and had the potential to delay the appropriate care or treatment the resident needed. Findings: During a review of Resident 22's Admission Record, the Admission Record indicated the facility originally admitted the resident on 1/25/2024 and readmitted the resident on 10/12/2024 with diagnoses including sepsis (a serious condition in which the body responds improperly to an infection, where infection-fighting processes turn on the body, causing the organs to work poorly), metabolic encephalopathy (a problem in the brain caused by a chemical imbalance in the blood), and chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood well). The Admission Record indicated Resident 22's preferred language is Farsi. During a review of Resident 22's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 10/19/2024, the MDS indicated the resident had severely impaired cognition (thought processes) and required maximal assistance from staff for eating, oral hygiene, and upper body dressing. The MDS indicated that Resident 22 was dependent on two or more helpers for toileting and personal hygiene, showering, and lower body dressing. During a concurrent observation and interview on 12/03/2024 at 2:34 p.m. in Resident 22 's room with Certified Nursing Assistant 3 (CNA 3), observed CNA 3 wheeling Resident 22 out of the bathroom in a wheelchair. The surveyor did not observe any communication board (a tool that includes pictures that help residents communicate their healthcare and every-day needs to facility staff) in Resident 22's room or attached to the resident's wheelchair. CNA 3 stated that Resident 22 only speaks Persian, but CNA 3 never saw a communication board in the resident's room. During a concurrent interview and record review on 12/03/2024 at 3:43 p.m., with the Social Service Director (SSD), Resident 22's care plan (a document that outlines a patient's health information, conditions, treatments, care services, and goals) addressing the resident's language barrier, initiated on 2/14/2024 and revised 12/23/2024, was reviewed. The SSD stated that the care plan indicated that Resident 22 has a communication impairment (having difficulty understanding or expressing thoughts through speaking, writing or body language) because the resident speaks Farsi. The SSD stated that the interventions of the care plan indicated to provide Resident 22 with a communication board. The SSD stated that this deficient practice had the potential to leave Resident 22's needs unmet. During an interview on 11/5/2024 at 11:20 a.m. with the Director of Nursing (DON), the DON stated that the communication board had to be provided to Resident 22 according to the resident's care plan interventions. The DON stated if a communication board was not in place, then the staff would not be able to communicate with the resident effectively and address the resident's needs. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated policy of Interpreter services, last reviewed 10/2024, the policy indicated the facility shall have communication boards for residents, who are unable to communicate.

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	055013	A. Building B. Wing	12/05/2024

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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** 44309 Based on observation, interview, and record review the facility failed to provide services that promote the prevention of pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) injury for one of three sampled residents (Resident 51) as evidenced by failing to monitor the functionality of the resident's low air loss mattress (LALM-mattress designed to treat and prevent pressure ulcers) to ensure the LALM was working properly. This deficient practice had the potential for Resident 51 to develop a new pressure injury. Findings: During a review of Resident 51's Admission Record, the Admission Record indicated the facility originally admitted the resident on 10/21/2021, and readmitted on [DATE], with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and muscle weakness. During a review of Resident 51's Minimum Data Set (MDS -a resident assessment tool) dated 10/15/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 51 was dependent on staff (helper does all of the effort) for eating, toileting hygiene, oral hygiene, personal hygiene, upper and lower body dressing, and showering/bathing. The MDS further indicated that Resident 51 was at risk for developing pressure ulcers and had pressure reducing device for bed. During a review of Resident 51's physician order dated 6/24/2024, the order indicated to apply a LALM for skin management. During a review of Resident 51's Care Plan (CP-a document that outlines how a patient`s health care needs will be met) for at risk for impaired skin integrity initiated on 1/3/2024, the CP indicated a care plan goal that the resident will have minimized risks for the development of skin breakdown. The care pan interventions were to utilize LALM and bilateral (both) heel protector for skin management, report any signs of skin breakdown, and to avoid shearing of skin while assisting the resident with positioning, transferring, and turning. During a concurrent observation, and interview on 12/4/2024 at 9:07 a.m., with Licensed Vocational Nurse 5 (LVN 5) inside Resident 51`s room, Resident 51 was observed lying on his bed with a LALM. LVN 5 stated that the LALM is powered on however, the display does not show any information. She (LVN 5) stated that normally the LALM is powered on and there is information displayed on the panel`s screen. She (LVN 5) stated that she does not remember the last time she observed Resident 51`s LALM display information on its panel. She (LVN 5) stated that she will call the company to report this issue. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview and record review on 12/5/2024 at 1:40 p.m., with LVN 5, Resident 51`s Treatment Administration Record (TAR), Medication Administration Record (MAR) and physician orders were reviewed. LVN 5 stated licensed staff are required to monitor a resident`s LALM once every shift and document on the resident`s MAR or TAR. LVN 5 stated she is unable to find any documentation regarding the monitoring of Resident 51`s LALM in his TAR or MAR. LVN 5 stated Resident 51`s physician order for LALM was not placed on the administrative section of the order. Therefore, the order was not transferred to Resident 51`s TAR or MAR as a task to be completed. She (LVN 5) stated this order was missed and it was never carried out. LVN 5 further stated she is unable to say for how long Resident 51`s LALM panel was off, or whether or not his LALM was functioning at the time of observation. LVN 5 stated the LALM company representative checked Resident 51`s LALM yesterday and replaced the machine. LVN 5 stated the potential outcome of not monitoring a resident`s LALM to make sure it is functioning is placing the resident at risk for development of pressure injuries or the worsening of their existing pressure injuries. During an interview on 12/5/2024 at 2:00 p.m., with the Director of Nursing (DON), the DON stated staff are required to monitor and check residents' LALM to ensure that it is functioning. The DON stated licensed staff are required to document their monitoring of LALM in the resident`s TAR. The DON stated Resident 51`s LALM panel was off, and staff did not notice that the unit was off. The DON stated there is no documentation regarding monitoring of Resident 51`s LALM in his TAR or MAR. The DON stated the potential outcome is the development of a skin breakdown and harm to the resident.  During a review of the facility`s policy and procedure (P&P) titled Resident Pressure Redistribution Devices-Air Loss Mattress, reviewed 10/2022, the P&P indicated that the purpose of this policy is to ensure the effectiveness of air loss mattress use and cleaning. All residents utilizing an air loss mattress will be monitored appropriately to ensure pertinent and effective use and cleaning.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 44309 Based on interview, and record review, the facility failed to act upon a recommendation from the Pharmacy Consultant (PC -a healthcare specialist who provides expert advice on medications and pharmaceutical services, including patient safety) to clarify the behavior manifestation for the use of Seroquel (a psychoactive medication-any medication capable of affecting the mind, emotions, and behavior) for one of five sampled residents (Resident 64) reviewed for unnecessary medication. This deficient practice increased the risk of receiving medication that was not optimal for Resident 64's medical condition and increased the risk of adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the medication therapy. Findings: During a review of Resident 64's Admission Record, the Admission Record indicated the facility admitted the resident on 5/10/2024, with diagnoses including major depressive disorder a persistent feeling of sadness or a lack of interest in outside stimuli), dementia (a progressive state of decline in mental abilities), and psychotic disorders (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool) dated 11/16/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 64 did not exhibit potential indicators for psychosis such as hallucinations (a sight, sound, smell, taste, or touch that a person believes to be real but is not real) and delusions (having false or unrealistic beliefs). The MDS further indicated that Resident 64 was taking antipsychotic and antidepressant medications. During a review of Resident 64`s Physician Order dated 5/10/2024, the order indicated to administer Seroquel 25 mg by mouth at bedtime for psychotic disorder with delusions due to dementia manifested by sudden verbal agitation.  During a review of Resident 64`s Physician Order dated 7/30/2024, the order indicated to administer Seroquel 25 mg by mouth at bedtime for psychotic disorder with delusions due to dementia manifested by sudden verbal agitation which may present a danger to self or others. During a review of the facility's Pharmacy Consultant (PC) Monthly Regimen Review (MRR- a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication), dated 9/17/2024, the MMR indicated that Resident 64 had been on Seroquel with target behavior of sudden verbal agitation. The review indicated to clarify what the resident said and how this presented a danger to self and others. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 64`s Psych Interdisciplinary Team meeting (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their client) with PC form dated 11/18/2024, the IDT form indicated that the IDT team recommended a Gradual Dose Reduction (GDR- the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for Seroquel to 12.5 mg at bedtime. The IDT form further indicated that the GDR recommendation will be sent to Resident 64`s primary care physician for review and order.  During a review of Resident 64`s Physician Order dated 11/18/2024, the order indicated to administer Seroquel 12.5 mg by mouth at bedtime for psychotic disorder with delusions due to dementia manifested by sudden verbal agitation which may present a danger to self or others. During an interview on 12/5/2024 at 1:50 p.m., with LVN 5, LVN 5 stated that Resident 64`s Seroquel order did not indicate the specific behavior to monitor. The LVN 5 stated sudden verbal agitation is not an indication to administer Seroquel. She (LVN 5) stated Resident 64, who has dementia can have sudden verbal agitation when she is hungry, when she tries to make her needs known, or for any other reasons. She (LVN 5) stated the order for Resident 64`s Seroquel did not include a clear indication and the specific behavior to be monitored and requires clarification. She (LVN 5) stated the potential outcome of not having a clear indication and measurable target behavior (the specific, undesirable behavior that a medication is intended to reduce or manage) is inaccurate monitoring and exposure of the resident to side effects of the medication. During a concurrent interview and record review on 12/4/2024 at 3:50 p.m., with the facility`s Director of Nursing (DON), Resident 64`s physician orders and MRRs were reviewed. The DON stated Resident 64`s physician order for Seroquel did not include a specific measurable behavior to be monitored by a licensed staff member. The DON stated based on MRR dated 9/17/2024, the PC indicated that Resident 64 had been on Seroquel with target behavior of sudden verbal agitation. The PC further indicated to clarify what the resident said and how this presented a danger to self and others. However, the DON stated the facility failed to follow up on the PC recommendation to clarify this order. The DON stated the potential outcome of not following up on the PC recommendation to clarify the order is inaccurate monitoring and inability to measure efficacy of the medication for the resident. During a review of the facility's Policies & Procedures (P&P) titled, Psychotropic medication Assessment and Monitoring, last reviewed 10/2024, the P&P indicated that psychotropic drugs are used only when necessary and then at the lowest effective dose. The IDT team assesses and monitors the appropriateness, effectiveness and side effects associated with psychotropic medications for each resident. The PC reviews the appropriateness of the psychotropic medications order as part of each drug regimen. If at any time during the assessment for monitoring process, the psychotropic medication order is found to be inappropriate, the Director of Nursing is to be notified and the attending physician will be called for clarification. The behavior of residents receiving antipsychotic medication will be monitored by the Registered Nurses or LVN at appropriate intervals, as determined by the IDT using the behavior monitoring record. Record behavior, interventions and effectiveness of interventions taken in the behavior monitored. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policies & Procedures (P&P) titled, Consultant Pharmacist Reports, last reviewed 1/22/2024, the P&P indicated recommendations are acted upon and documented by the facility staff and or the prescriber. Physicians accepts and acts upon suggestion or rejects and provides an explanation for disagreeing. The Director of nursing or designated licensed nurse address and document recommendations that do not require a physician intervention.

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	055013	A. Building B. Wing	12/05/2024

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview, and record review, the facility failed to ensure two (2) of five (5) sampled residents (Residents 61 and 64) were free from unnecessary use of psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to ensure: 1. Resident 61 had a specific, measurable target behaviors (the specific, undesirable behavior that a medication is intended to reduce or manage) related to the use of Zoloft (medication to treat depression [a persistent feeling of sadness or a lack of interest in outside stimuli]). 2. Resident 64 had a specific, measurable target behaviors related to the use of Seroquel (medication used to treat mental illness). These deficient practices had the potential to place Resident 61 and Resident 64 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment (being weakened) or decline (gradually become less) in the resident's mental, physical condition, functional, and psychosocial status. Findings: 1. During a review of Resident 61's Admission Record, the Admission Record indicated the facility admitted the resident on 9/1/2024, with diagnoses including major depressive disorder (a persistent feeling of sadness or a lack of interest in outside stimuli), dementia (a progressive state of decline in mental abilities), and attention to gastrostomy (GT- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 61's Minimum Data Set (MDS - a resident assessment tool) dated 9/7/2024, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 61 was rarely/never understood and was dependent to staff (helper does all of the effort) for eating, oral hygiene, toileting hygiene, showering/bathing and personal hygiene. The MDS further indicated that Resident 61 was taking antidepressant medication (medication used to treat depression). During a review of Resident 61`s physician History and Physical (H&P) dated 11/27/2024, the H&P indicated that the resident was non-verbal and unable to make his own needs known.  During a review of Resident 61`s Physician Order dated 11/19/2024, the order indicated to administer Zoloft 25 milligrams (mg-a unit of measure of mass) via GT, once a day for depression manifested by verbalization of sadness. The order further indicated to monitor the resident`s behavior and verbalization of sadness and side effect of Zoloft during every shift. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 61`s Medication Administration Records (MAR), the MAR indicated that resident received Zoloft on 11/19/2024, and 11/26/2024 through 11/30/2024.  During a concurrent observation and interview on 12/2/2024 at 10:26 a.m., at Resident 61`s bedside, the resident was observed laying on his bed with his eyes open. Resident 61`s Responsible Party (RP1) was present at his bedside. RP1 stated Resident 61 is not able to talk.  During a concurrent interview and record review on 12/5/2024 at 11:00 a.m., with MDS Coordinator (MDSC), Resident 61`s physician orders and MDS were reviewed. The MDSC stated according to Resident 61`s MDS dated [DATE], the resident was not able to answer any questions and was not interviewable. The MDSC stated the reason the physician ordered Zoloft is due to Resident 61's verbalization of sadness, however, the resident is not able to verbalize his feelings as he is non-verbal. The MDSC stated Resident 61`s Zoloft's indication for use is incorrect, unclear, and requires clarification. The MDSC stated all psychotropic medications are required to have a specific and clear indication for use and measurable target behaviors so the licensed staff can monitor the frequency of the behavior. During an interview on 12/5/2024 at 1:46 p.m., with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 61 is nonverbal and unable to make his needs known. LVN 5 stated Resident 61`s Zoloft order did not indicate the specific behavior to be monitored. LVN 5 stated the potential outcome of not indicating the specific behavior to be monitored is inaccurate monitoring and inability to measure the effectiveness of the medication for the resident. 2. During a review of Resident 64's Admission Record, the Admission Record indicated the facility admitted the resident on 5/10/2024, with diagnoses including major depressive disorder, dementia, and psychotic disorders (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 64's Minimum Data Set, dated dated dated [DATE], the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 64 did not exhibit potential indicators for psychosis such as hallucinations (a sight, sound, smell, taste, or touch that a person believes to be real but is not real) and delusions (having false or unrealistic beliefs). The MDS further indicated that Resident 64 was taking antipsychotic and antidepressant medications. During a review of Resident 64`s Physician Order dated 5/10/2024, the order indicated to administer Seroquel 25 mg by mouth at bedtime for psychotic disorder with delusions due to dementia manifested by sudden verbal agitation.  During a review of Resident 64`s Physician Order dated 7/30/2024, the order indicated to administer Seroquel 25 mg by mouth at bedtime for psychotic disorder with delusions due to dementia manifested by sudden verbal agitation which may present a danger to self or others. During a review of the facility's Pharmacy Consultant (PC) Monthly Regimen Review (MRR), dated 9/17/2024, the MRR indicated that Resident 64 had been on Seroquel with target behavior of sudden verbal agitation. The review indicated to clarify what the resident said and how this presented a danger to self and others. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64`s Psych Interdisciplinary Team meeting (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of their client) with PC form dated 11/18/2024, the IDT form indicated that the IDT team recommended a Gradual Dose Reduction (GDR- the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) for Seroquel to 12.5 mg at bedtime. The IDT form further indicated that the GDR recommendation will be sent to Resident 64`s primary care physician for review and order.  During a review of Resident 64`s Physician Order dated 11/18/2024, the order indicated to administer Seroquel 12.5 mg by mouth at bedtime for psychotic disorder with delusions due to dementia manifested by sudden verbal agitation which may present a danger to self or others. During an interview on 12/5/2024 at 1:50 p.m., with LVN 5, LVN 5 stated that Resident 64`s Seroquel order did not indicate the specific behavior to monitor. The LVN 5 stated sudden verbal agitation is not an indication to administer Seroquel. She (LVN 5) stated Resident 64, who has dementia can have sudden verbal agitation when she is hungry, when she tries to make her needs known, or for any other reasons. She (LVN 5) stated the order for Resident 64`s Seroquel did not include a clear indication and the specific behavior to be monitored and requires clarification. She (LVN 5) stated the potential outcome of not having a clear indication and measurable target behavior is inaccurate monitoring and exposure of the resident to side effects of the medication. During a concurrent interview and record review on 12/4/2024 at 3:50 p.m., with the Director of Nursing (DON), Resident 64`s physician orders and MRRs were reviewed. The DON stated Resident 64`s physician order for Seroquel did not include a specific measurable behavior to be monitored by a licensed staff member. The DON stated the facility failed to follow up on PC recommendation dated 9/17/2024, to clarify this order. The DON stated the potential outcome of not indicating a specific measurable behavior to monitor is inaccurate monitoring and inability to measure efficacy of the medication for the resident. During a review of the facility's Policies & Procedures (P&P) titled, Psychotropic medication Assessment and Monitoring, last reviewed 10/2024, the P&P indicated that psychotropic drugs are used only when necessary and then at the lowest effective dose. The IDT team assesses and monitors the appropriateness, effectiveness and side effects associated with psychotropic medications for each resident. The PC reviews the appropriateness of the psychotropic medications order as part of each drug regimen. If at any time during the assessment for monitoring process, the psychotropic medication order is found to be inappropriate, the Director of Nursing is to be notified and the attending physician will be called for clarification. The behavior of residents receiving antipsychotic medication will be monitored by the Registered Nurses or LVN at appropriate intervals, as determined by the IDT using the behavior monitoring record. Record behavior, interventions and effectiveness of interventions taken in the behavior monitored.

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	055013	A. Building B. Wing	12/05/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to maintain a medication error rate below 5 percent (%) by having two medication errors out of 32 opportunities contributing to an overall error rate of 6.25 % for one of nine residents (Resident 61) observed during the Medication Administration facility task. These deficient practices resulted in the omission of medications which could have resulted in severe health complications. Findings: During a review of Resident 61's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (high blood sugar), BPH, Parkinson's disease, dysphagia (difficulty swallowing), and presence of a G-Tube (a plastic tube inserted into the stomach to infuse medications for one who has problems swallowing). During a review of Resident 61' s Minimum Data Set (MDS, a resident assessment tool), dated 9/07/2024, the MDS indicated Resident 61 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 61 was dependent (helper does all the effort) on staff for eating, dressing, and personal hygiene. During a review of Resident 61's Physician's Orders, the physician's orders indicated the following: - Terazosin capsule 2 milligrams (mg, a metric unit of measurement for medication dosage) by G-Tube, once daily for BPH, dated 11/25/2024. - Sinemet tablet 25-100 mg by G-Tube, three times a day at 8:30 a.m., 12:30 p.m., and 4:30 p.m., dated 11/26/2024. - Ipratropium-albuterol solution for nebulization (a medication to treat those with breathing problems given by a nebulizer, a device to administer medication in the form of a mist) 2.5 mg/3 milliliters (ml, a metric unit of measurement for medication dosage) for shortness of breathing or wheezing (a high-pitched sound made when breathing is restricted) by hand held nebulizer (HHN, or can be administered through a face mask if resident can not hold a nebulizer) every six hours, dated 11/25/2024. - Potassium chloride liquid 40 milliequivalents in 15 milliliters (mEq/ml, a metric unit of measurement for medication dosage) by G-tube for hypokalemia (low potassium, a mineral that is essential for proper body functioning), twice a day for two days, dated 12/03/2024. - Humalog insulin solution (a medication to decrease high blood sugar) 100 units/ ml (a unit of measure for insulin) per sliding scale: (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	o If blood sugar is less than 70 milligrams per deciliter (mg/dL, a unit of measurement for blood sugar), call the physician. o If blood sugar is 71 to 150 mg/dL, give 0 units (a unit of measure for insulin). o If blood sugar is 151 to 200 mg/dL, give 1 unit. o If blood sugar is 201 to 250 mg/dL, give 2 units. o If blood sugar is 251 to 300 mg/dL, give 3 units. o If blood sugar is 301 to 350 mg/dL, give 4 units. o If blood sugar is 351 to 400 mg/dL, give 5 units. o If blood sugar is greater than (>) 400 mg/dL, give 6 units. o If blood sugar is greater than 400, call the physician. Subcutaneous (injected by needle into the fat under the skin) for diabetes mellitus every four hours, dated 12/03/2024. During a review of Resident 61's Care Plan for Parkinson's Disease, created on11/25/2024, the care plan indicated a goal that the resident's signs and symptoms in the neurological system will be identified and treated upon detection. The care plan indicated an intervention to follow medical regimen as ordered. During a review of Resident 61's Medication Administration Record (a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), covering the dates 12/01/2024 to 12/04/2024, the MAR indicated the following: - Sinemet tablet on 12/04/2024 at 8:30 a.m. was not given. - Terazosin capsule on 12/04/2024 at 8:30 a.m. was not given. During a review of Resident 61's Nursing Progress Notes, the nursing progress note, dated 12/04/2024 at 11:44 a.m., indicated RN 2 called Resident 61's physician, MD 1 for clarification of which medications to give and which medications to hold. The nursing progress note indicated Sinemet, terazosin, and finasteride medications were to be given. During a medication pass observation with RN 1 on 12/04/2024, observed RN 1 completed giving Resident 61's medications at 10:20 a.m. Confirmed with RN 1 the medications given were: potassium chloride liquid by G-Tube, ipratropium-albuterol breathing treatment, and fingerstick taken with insulin coverage given for fingerstick of 323 mg/dL. No other medications were given at that time. During a concurrent interview and record review with RN 2, on 12/04/2024 at 11:04 a.m., reviewed Resident 61's physician's orders which indicated orders to give finasteride at bedtime, Sinemet in the morning and afternoon, and terazosin in the morning. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RN 1 on 12/04/2024 at 11:15 a.m., RN 1 stated they had received instructions from the night RN supervisor that all medications were to be held except for potassium chloride, blood sugar checks with insulin sliding scale insulin administration if indicated and the ipratropium-albuterol breathing treatment. During a phone interview with Resident 61's physician, (MD 1) and RN 2 on the line, on 12/04/2024 at 11:25 a.m., MD 1 stated they wanted all medications for BPH and Parkinson's disease are to be given. MD 1 stated Resident 61's bowel needed to rest and wanted to give certain medications that were most necessary. During a concurrent phone interview and record review with RN 3 on 12/04/2024 at 11:55 a.m., with RN 2 and the Director of Nursing (DON) on the line, RN 3 stated MD 1 told him by phone to hold certain medications while giving others. RN 3 stated he printed out a list of Resident 61's medications and wrote on that sheet which medications MD 1 wanted to give and which ones MD 1 wanted to hold. RN 3 stated he (RN 3) told RN 2 where Resident 61's Physician Orders printout was, RN 2 retrieved Resident 61's Physician's Order printout which indicated the medications finasteride, Sinemet, and terazosin should be given. These medications were indicated to give and were indicated with the word Give indicated in cursive handwriting (a style of writing that has joined letters written with the help of loops made without lifting the writing instrument from the paper) next to the medication name. RN 3 indicated that the Resident 61 Physician's Orders printouts with the words Hold and Give indicated in cursive handwriting next to the medication names was the document he made notes on before entering the hold orders in the computer system. During a concurrent interview and record review with the DON on 12/05/2024 at 8:14 a.m., reviewed Resident 61's 12/2024 MAR which covered the dates 12/01/2024 to 12/04/2024. The DON confirmed that the following medications were not given but should have been given: - Sinemet tablet on 12/04/2024 at 8:30 a.m. - Terazosin capsule on 12/04/2024 at 8:30 a.m. The DON stated that she knew the medications were not given as indicated by the words: Not Administered: On Hold next to these medications on the indicated dates and times. The DON stated this was important so that Resident 61 does not experience adverse side effects from BPH such as urinary problems and adverse side effects such as tremors for Parkinson's disease. During a review of the facility's policy and procedure titled, Medication Administration, last reviewed 1/22/2024, indicated medications must be administered in a timely manner and in accordance with the attending physician's written or verbal orders.

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	055013	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eisenberg Village	18855 Victory Bl Reseda, CA 91335

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to ensure residents were free from any significant medication errors for one of nine residents (Resident 61) investigated during the medication administration facility task by failing to: 1. Ensure Registered Nurse 1 (RN 1) administered the medications Sinemet (two medications combined into one medication to treat Parkinson's disease [(a nervous system disorder which leads to movement problems) and terazosin (a medication to treat benign prostatic hyperplasia (BPH, a non-cancerous condition that causes the prostate [a gland in the male reproductive system] to enlarge due to an overgrowth of cells), for one (Resident 61) of nine residents observed during the medication pass observation. 2. Ensure Licensed Vocational Nurse 4 (LVN 4) administered finasteride and Sinemet during the 3 p.m. to 11 p.m. shift on 12/03/2024 to Resident 61 These failures had the potential for Resident 61 to experience unwanted adverse effects such as tremors, and urination problems. Cross reference to F759. Findings: During a review of Resident 61's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (high blood sugar), BPH, Parkinson's disease, dysphagia (difficulty swallowing), and presence of a G-Tube (a plastic tube inserted into the stomach to infuse medications for one who has problems swallowing). During a review of Resident 61' s Minimum Data Set (MDS, a resident assessment tool), dated 9/07/2024, the MDS indicated Resident 61 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 61 was dependent (helper does all the effort) on staff for eating, dressing, and personal hygiene. During a review of Resident 61's Physician's Orders, the physician's orders indicated the following: - Terazosin capsule 2 milligrams (mg, a metric unit of measurement for medication dosage) by G-Tube, once daily for BPH, dated 11/25/2024. - Sinemet tablet 25-100 mg by G-Tube, three times a day at 8:30 a.m., 12:30 p.m., and 4:30 p.m., dated 11/26/2024. - Finasteride tablet 5 mg by G-Tube, once daily, dated 11/25/2024. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Ipratropium-albuterol solution for nebulization (a medication to treat those with breathing problems given by a nebulizer, a device to administer medication in the form of a mist) 2.5 mg/3 milliliters (ml, a metric unit of measurement for medication dosage) for shortness of breathing or wheezing (a high-pitched sound made when breathing is restricted) by hand held nebulizer (HHN, or can be administered through a face mask if resident can not hold a nebulizer) every six hours, dated 11/25/2024. - Potassium chloride liquid 40 milliequivalents in 15 milliliters (mEq/ml, a metric unit of measurement for medication dosage) by G-tube for hypokalemia (low potassium, a mineral that is essential for proper body functioning), twice a day for two days, dated 12/03/2024. - Humalog insulin solution (a medication to decrease high blood sugar) 100 units/ ml (a unit of measure for insulin) per sliding scale: o If blood sugar is less than 70 milligrams per deciliter (mg/dL, a unit of measurement for blood sugar), call the physician. o If blood sugar is 71 to 150 mg/dL, give 0 units (a unit of measure for insulin). o If blood sugar is 151 to 200 mg/dL, give 1 unit. o If blood sugar is 201 to 250 mg/dL, give 2 units. o If blood sugar is 251 to 300 mg/dL, give 3 units. o If blood sugar is 301 to 350 mg/dL, give 4 units. o If blood sugar is 351 to 400 mg/dL, give 5 units. o If blood sugar is greater than (>) 400 mg/dL, give 6 units. o If blood sugar is greater than 400, call the physician. Subcutaneous (injected by needle into the fat under the skin) for diabetes mellitus every four hours, dated 12/03/2024. During a review of Resident 61's Care Plan for Parkinson's Disease, created 11/25/2024, the care plan indicated a goal that the resident's signs and symptoms in the neurological system will be identified and treated upon detection. The care plan indicated an intervention to follow medical regimen as ordered. During a review of Resident 61's Care Plan for Altered Elimination Pattern, created 9/20/2024, the care plan indicated a goal that the resident will remain free of injury within the safe confines of his environment. The care plan indicated an intervention to give BPH medications as ordered. During a review of Resident 61's Medication Administration Record (a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/01/2024 to 12/04/2024, the MAR indicated the following: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Finasteride tablet on 12/03/2024 at 8:30 p.m. was not given. - Sinemet tablet on 12/03/2024 at 8:30 a.m., 12:30 p.m. and 4:30 p.m. and on 12/04/2024 at 8:30 a.m. was not given. - Terazosin capsule on 12/03/2024 at 8:30 a.m. and 12/04/2024 at 8:30 a.m. was not given. During a review of Resident 61's Nursing Progress Notes, the nursing progress note, dated 12/04/2024 at 11:44 a.m., indicated RN 2 called Resident 61's physician, MD 1 for clarification of which medications to give and which medications to hold. The nursing progress note indicated Sinemet, terazosin, and finasteride medications were to be given. During a medication pass observation with RN 1 on 12/04/2024, observed RN 1 completed giving Resident 61's medications at 10:20 a.m. Confirmed with RN 1 the medications given were: potassium chloride liquid by G-Tube, ipratropium-albuterol breathing treatment, and fingerstick taken with insulin coverage given for fingerstick of 323 mg/dL. No other medications were given at that time. During a concurrent interview and record review with RN 2, on 12/04/2024 at 11:04 a.m., reviewed Resident 61's physician's orders which indicated orders to give finasteride at bedtime, Sinemet in the morning and afternoon, and terazosin in the morning. During an interview with RN 1 on 12/04/2024 at 11:15 a.m., RN 1 stated they had received instructions from the night RN supervisor that all medications were to be held except for potassium chloride, blood sugar checks with insulin sliding scale insulin administration if indicated and the ipratropium-albuterol breathing treatment. During a phone interview with Resident 61's Physician, MD 1 and RN 2 on the line, on 12/04/2024 at 11:25 a.m., MD 1 stated MD 1 wanted all medications for BPH and Parkinson's disease to be given. MD 1 stated Resident 61's bowel needed to rest and wanted to give certain medications that were most necessary. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 12/04/2024 at 11:37 a.m., she (LVN 4) stated she had received instructions from the night RN supervisor, RN 3, that all medications were to be held except for potassium chloride, blood sugar checks with insulin sliding scale insulin administration if indicated, and the ipratropium-albuterol breathing treatment. LVN 4 stated she only gave those medications on 12/03/2024. The medications not given were Sinemet and finasteride. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent phone interview and record review with RN 3 on 12/04/2024 at 11:55 a.m., with RN 2 and the Director of Nursing (DON) on the line, RN 3 stated MD 1 told him by phone to hold certain medications while giving others. RN 3 stated he printed out a list of Resident 61's medications and wrote on that sheet which medications MD 1 wanted to give and which ones MD 1 wanted to hold. RN 3 stated he (RN 3) told RN 2 where Resident 61's Physician Orders printout was, RN 2 retrieved Resident 61's Physician's Order printout which indicated the medications finasteride, Sinemet, and terazosin should be given. These medications were indicated to give and were indicated with the word Give indicated in cursive handwriting (a style of writing that has joined letters written with the help of loops made without lifting the writing instrument from the paper) next to the medication name. RN 3 indicated that the Resident 61 Physician's Orders printouts with the words Hold and Give indicated in cursive handwriting next to the medication names was the document he made notes on before entering the hold orders in the computer system During a concurrent interview and record review with the DON on 12/05/2024 at 8:14 a.m., reviewed Resident 61's 12/2024 MAR dated 12/01/2024 to 12/04/2024. The DON confirmed that the following medications were not given but should have been given: - Finasteride tablet on 12/03/2024 at 8:30 p.m. - Sinemet tablet on 12/03/2024 at 8:30 a.m., 12:30 p.m. and 4:30 p.m. and on 12/04/2024 at 8:30 a.m. - Terazosin capsule on 12/03/2024 at 8:30 a.m. and 12/04/2024 at 8:30 a.m. The DON stated that she knew the medications were not given as indicated by the words: Not Administered: On Hold next to these medications on the indicated dates and times. The DON stated it was important to give these medications so that Resident 61 does not experience adverse side effects from BPH such as urinary problems and adverse side effects such as tremors for Parkinson's disease. During a review of the facility's policy and procedure titled, Medication Administration, last reviewed 1/22/2024, indicated medications must be administered in a timely manner and in accordance with the attending physician's written or verbal orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were stored in accordance with accepted professional principles in one of (Second Floor, Medication Cart 2) four medication carts inspected when Resident 10's discontinued medication, amlodipine (a medication to lower blood pressure) was not removed from the medication cart and disposed of. This deficient practice had the potential for Resident 10 to receive this medication which could have lowered the blood pressure below normal limits causing dizziness, and loss of consciousness. Findings: During a review of Resident 10's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included hypertensive heart disease (a group of heart problems that develop over time due to high blood pressure). During a review of Resident 10' s Minimum Data Set (MDS, a resident assessment tool), dated 10/14/2024, the MDS indicated Resident 10 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 10 needed setup help only (helper sets up or cleans up only) with eating and maximal assistance (helper does more than half the effort) with dressing. During a review of Resident 10's Physician's Orders, the physician's orders indicated an order for amlodipine tablet (a medication to lower blood pressure) 2.5 milligrams (mg, a metric unit of measurement for medications) at bedtime for hypertension (high blood pressure), dated 7/24/2024 and discontinued 10/04/2024. During a review of Resident 10's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 10/2024, the MAR indicated that the last date Resident 10 received amlodipine was 10/04/2024. During a medication cart observation and concurrent record review on 12/04/2024 at 4:05 p.m. with Registered Nurse 4 (RN 4) observed Resident 10's medications inside the Second Floor, Medication Cart 2. Checked Resident 10's blister packs (also known as bubble pack, a card holding usually medicinal tablets or capsules that are individually packaged in a clear plastic case sealed to the card) with Resident 10's Physician's orders. There was a bubble pack for amlodipine but no corresponding physician order. Reviewed Resident 10's Physician's Orders with RN 4 with a discontinued order for amlodipine, dated 10/04/2024. RN 4 stated the medication should have been removed when it was discontinued 10/04/2024. RN 4 stated this was important so that the medication could not be accidentally given to Resident 10. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Director of Nurses (DON) on 12/05/2024 at 8:14 a.m., the DON stated, when a medication is discontinued by a physician's order, it is to be removed immediately from the medication cart. The DON stated this is important to avoid a medication error of the medication accidentally being given to a resident. During a review of the facility's policy and procedure titled, Disposal of Medications and Medication-Related Supplies, last reviewed 1/22/2024, the policy indicated medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue to avoid inadvertent administration (unintentional medication administration).

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	055013	A. Building B. Wing	12/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on observation, interview, and record review, the facility failed to: 1. Store food in accordance with professional standards for food service safety by failing to: a. Label one container of oatmeal with a use by date label. b. Label one container of powdered sugar with a use by date label. c. Label one container of quinoa with a use by date label. d. Label one container of bulgur with a use by date label. e. Label one container of cream of wheat with a use by date label. f. Label one bag of lemon curd with a use by date label. g. Label one container of chicken with a use by date label. e. Label one container of ground beef with a use by date label. 2. Ensure the chlorine test strips used to check that the sanitizing solution was not expired. These deficient practices had the potential for residents in the facility to be at risk for food borne illness (illness caused by food contamination with bacteria, viruses, parasites, or toxins). Findings: 1. During a concurrent observation and interview on [DATE] at 8:00 a.m., with the Dietary Supervisor (DS), observed in the storage room one bin of oatmeal, one bin of powdered sugar, one bin of quinoa, one bin of bulgur, and one container of cream of wheat without a use by date label. During a concurrent observation and interview on [DATE] at 8:00 a.m., with the Dietary Supervisor (DS), observed in the walk-in refrigerator one container of lemon curd, one container of defrosting chicken, and one container ground beef without use by date labels. The DS stated there should have been a label with a use by date and if there was not, the residents could get sick from eating food that are past its use by due date. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 8:30 a.m., with Kitchen Supervisor (KS 1), observed KS 1 checking the concentration of the chlorine solution (solution used to sanitize the dishes) in the dish washer machine with a chlorine test strip (measures the concentration of free chlorine [chemical element that used to kill bacteria in water]). The surveyor observed that the test paper being used to test the sanitizing solution had an expiration date of [DATE]. KS 1 stated the testing equipment, such as test strips should not be expired to ensure adequate washing and sufficient concentration of sanitizing solution is present to effectively clean and sanitize dishware. During an interview on [DATE] at 3:30 PM, the Director of Nursing (DON), the DON stated food should have been labeled with use by date and should have always had a use by date label. The DON stated if the food was not labeled, the food could go bad, and the facility would want to prevent that. During a review of facility's policy and procedure (P&P) titled, Dietary Delivery and Storage safety, last reviewed on [DATE], the policy indicated that delivered dietary items should be labeled and dated. During a review of facility's policy and procedure (P&P) titled, Dietary Delivery and Storage General Sanitation, last reviewed on [DATE], the policy indicated: Sanitizing solution containers with Quaternary sanitizer must maintain sanitizer concentration to the manufacturer's recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eisenberg Village	18855 Victory Bl Reseda, CA 91335

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review, the facility failed to: 1. Observe infection control guidelines when Registered Nurse 1 (RN 1) was observed leaving a resident's room during a medication pass observation while still wearing an isolation gown for one (Resident 61) of 12 residents who were on enhanced barrier precautions (EBP-a method of using personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments] to reduce the spread of pathogens between residents in skilled nursing facilities). This deficient practice had the potential to increase the risk of spreading infection to other residents. 2. Ensure Housekeeper 1 (HK 1) used the eye protective personal equipment (PPE-goggles or face shields used to prevent or minimize exposure to respiratory droplets [a small droplet of saliva or mucus that is produced when someone exhales]) while cleaning inside the resident's room for one (Resident 68) out one resident sampled, who was on Contact/Droplet Precaution (Steps that healthcare staff take to reduce the spread of pathogens between residents in skilled nursing facilities). This deficient practice had the potential to increase the risk of spreading infection to other residents. 3. Implement its policy and procedure titled, Installation of Eye Drops (putting eye drops into residents' eyes) by failing to ensure Licensed Vocational Nurse 3 (LVN 3) washed and dried his hands thoroughly before treating each eye while administering eye drops to one (Resident 72) out of five residents investigated during review of the infection control task. This deficient practice had the potential to cause cross contamination (unintentional transfer of bacteria/germs or other contaminants from one surface to another) of infection (occurs when harmful microorganisms, such as bacteria or viruses enter the body and multiply) between Resident 72's eyes. Findings: 1. During a review of Resident 61's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (high blood sugar), BPH, Parkinson's disease, dysphagia (difficulty swallowing), and presence of a G-Tube (a plastic tube inserted into the stomach to infuse medications for one who has problems swallowing). During a review of Resident 61' s Minimum Data Set (MDS, a resident assessment tool), dated 9/07/2024, the MDS indicated Resident 61 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 61 was dependent (helper does all the effort) on staff for eating, dressing, and personal hygiene. (continued on next page)

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	055013	A. Building B. Wing	12/05/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 61's Physician's Orders, the physician's orders indicated the following: - Humalog insulin solution (a medication to decrease high blood sugar) 100 units/ ml (a unit of measure for insulin) per sliding scale: o If blood sugar is less than 70 milligrams per deciliter (mg/dL, a unit of measurement for blood sugar), call the physician. o If blood sugar is 71 to 150 mg/dL, give 0 units (a unit of measure for insulin). o If blood sugar is 151 to 200 mg/dL, give 1 unit. o If blood sugar is 201 to 250 mg/dL, give 2 units. o If blood sugar is 251 to 300 mg/dL, give 3 units. o If blood sugar is 301 to 350 mg/dL, give 4 units. o If blood sugar is 351 to 400 mg/dL, give 5 units. o If blood sugar is greater than (>) 400 mg/dL, give 6 units. o If blood sugar is greater than 400, call the physician. Subcutaneous (injected by needle into the fat under the skin) for diabetes mellitus every four hours, dated 12/03/2024. During a medication pass observation with RN 1 on 12/04/2024 at 9:45 a.m., observed RN 1 taking a fingerstick (pricking the finger of a resident to obtain blood to measure how much glucose is in the blood) for Resident 61. RN 1 then removed her gloves and exited Resident 61's room while still wearing an isolation gown to get Resident 61's insulin from the medication cart. One of RN 1's gowned arms touched the medication cart. When asked why RN 1 was still wearing the isolation gown after exiting a resident's room on EBP precautions, RN 1 stated she should have removed the isolation gown before exiting the room. RN 1 removed the isolation gown. RN 1 stated it is important to follow EBP guidelines to prevent the spread of infection. During an interview with the Director of Nursing (DON) on 12/05/2024 at 8:14 a.m., the DON stated staff providing care for residents who are on EBP, the practice is to remove the isolation gown and gloves before leaving a resident's room. The DON stated RN 1 should have removed the gown before exiting Resident 61's room. The DON stated this was important to prevent the spread of infection. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eisenberg Village	18855 Victory Bl Reseda, CA 91335

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions, revised 4/23/2024, the policy indicated EBP is used in conjunction with standard precautions (a set of infection control practices that are used to prevent the spread of disease in healthcare settings, such as hand washing) and expand the use of PPE during high-contact resident care activities. The policy indicated EBP are to be used for residents with indwelling medical devices, such as a G-Tube, even if the resident is not known to be infected or colonized with a multidrug-resistant organism (MDRO, bacteria that are resistant to three or more classes of antimicrobial drugs). The policy indicated the PPE: gloves and gown, are to be used in maintaining EBP. 47883 2. During a review of Resident 68's Admission Record, the Admission Record indicated the facility admitted the resident on 7/1/2023 with diagnoses including Alzheimer's disease (a brain disorders the slowly destroys memory and thinking skills and eventually, the ability to carry out the simplest tasks), peripheral vascular disease (reduced circulation of blood to a body part due narrowed or blocked vessels), and diverticulosis (a condition where small pouches, called diverticula, form in the walls of the colon). During a review of Resident 68's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/7/2024, the MDS indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The resident required set up/supervision assistance from staff for most activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 68's physician's orders, dated 11/20/2024, an order indicated to put the resident on contact and droplet precautions isolation for respiratory syncytial virus (RSV-is a common respiratory virus that infect the throat, lungs, and nose) from 11/20/2024 to 12/05/2024. During an observation on 12/4/2024 at 12:00 p.m., observed Resident 68's room had signage which indicated Resident 68 was on contact and droplet precaution. The signage also indicated instructions to don a gown, mask, gloves, and eye protection (goggles) when entering the resident's room. During an observation on 12/4/2024 at 12:01 p.m. in Resident 68's room, observed Housekeeper 1(HK 1) enter Resident 68's room. HK1 was observed wearing gloves, gown, and mask, but not wearing any eye protection. During a concurrent observation and interview on 12/4/2024 at 12:05 p.m. with Infection Prevention Nurse (IP), the IP confirmed the finding and stated she (IP) observed HK 1 cleaning inside Resident 68's room without wearing an eye protective equipment. The IP stated that according to the facility's policy regarding contact and droplet precautions, HK 1 should have donned eye protective equipment prior to performing the room cleaning. During an interview on 11/20/2024 at 11:20 a.m. with the Director of Nursing (DON), the DON stated that failure to wear eye protection when entering a room on contact /droplet isolation may lead to spread an infection among residents in the facility. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eisenberg Village	18855 Victory Bl Reseda, CA 91335

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Guidelines for isolation Precautionslast reviewed on 1/22/2024, the policy indicated that : Contact precautions require staff don PPE-gloves, gown, and eye protection .Droplet precautions are used to reduce transmission of infectious agents from close respiratory or mucous membrane , i.e. less than three (3) feet . 3. During a review of Resident 72's Admission Record, the Admission Record indicated that the facility initially admitted Resident 72 on 1/18/2024 with diagnoses including dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities), chronic heart failure (a long term condition in which a heart cannot pump blood well enough to meet the body needs), and dry eye syndrome (a condition that occurs when the lacrimal glands [the tear glands responsible for producing tears] do not produce enough tears). During a review of Resident 72's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 10/24/2024, the document indicated that the resident had severely impaired cognition (a severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 72 required moderate-to- maximal assistance for eating, dressing, toileting, personal hygiene, and shower transfer. The MDS indicated that Resident 72 had moderately impaired vision and was wearing glasses. During the review of Resident 72's Physician Order Report, dated 12/1/2024, the document indicated the following physician orders: Soothe XP drops (eye drops containing a light mineral oil and used to treat dry eye syndrome) 1-4.5% (%- unit of measurement of concentration) 1 drop in each eye at 8:30 a.m., 12:30 p.m., 4:30 p.m. dated 01/18/2024. During a medication administration observation on 12/4/2024 at 11:39 a.m. in Resident 72's room, the surveyor observed LVN 3 administering Soothe XP one (1) drop to both of Resident 72's eyes. LVN 3 washed his hands with soap and water and administered Soothe XP one (1) drop in Resident 72's right eye. Then, without washing his hands, proceeded to administer Soothe XP one (1) drop in Resident 72's left eye. During an interview on 12/4/2024 at 11:40 a.m., LVN 3 stated that he (LVN 3) did not know that he had to clean hands before treating each eye when administering eye drops. During an interview on 12/4/2024 at 12:05 p.m. with the Infection Preventionist (IP), the IP was not aware that licensed staff had to clean hands before treating each eye when administering eye drops. During an interview on 12/5/2024 at 11:20 a.m. with the Director of Nursing (DON), the DON stated that according to facility policy, during the administration of medication in both eyes of the resident the licensed staff has to clean hands before treatment of each eye. The DON stated that failure to properly perform hand hygiene during administration of eye drops for Resident 72 may lead to cross contamination of infection between the resident's left and right eyes. During a review of the facility policy named Installation of Eye Drops, last reviewed on 1/21/2024, the policy stated: should both eyes require instillation, wash and dry your hands thoroughly before treating each eye. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055013	A. Building B. Wing	12/05/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility policy named Hand washing/Hand hygiene, last reviewed on 1/22/2024, the policy stated: This facility considers hand hygiene the primary means to prevent the spread of infection.