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	02/26/2026

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to monitor a resident's orthostatic blood pressure (taking blood pressure measurements taken to detect a significant drop in blood pressure when moving from lying/sitting to standing) who was prescribed an antipsychotic medication (a medication used to treat psychosis [a mental condition in which thought and emotions are so affected that contact is lost with external reality]) for 2 (Resident 3 and Resident 10) out of five residents investigated for unnecessary medications. This had the potential for Resident 3 and Resident 10 to have orthostatic hypotension (sudden, severe drop in blood pressure upon standing) side effects such as lightheadedness, syncope (fainting), placing Resident 10 at risk for fall. Findings: a. During a review of Resident 3's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 3 on 2/18/2019, and was re-admitted on [DATE] with diagnoses including syncope (fainting or passing out), dementia (loss of cognitive functioning-thinking, remembering, and reasoning) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure). During review of Resident 3's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 11/21/2025, MDS indicated Resident 3 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and maximal assistance (helper does more than half of the effort) to dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 3's Physician Order Report, the Physician Order Report indicated Resident 3 has a physician order for Zyprexa 2.5 milligrams (mg) by mouth twice a day, dated 2/11/2026. The Physician Order Report also indicated that Resident 3 has an order to monitor Zyprexa use: once per shift to monitor behavior and monitor side effects of the following: sedation, weight gain, cardiac arrythmias (heart rate abnormalities), anticholinergic effects (constipation, dry mouth, blurred vision, urinary retention [inability to fully empty bladder]), EPS (extrapyramidal symptoms-involuntary, uncontrollable muscle movements or restlessness), headache, agitation, dizziness, orthostatic hypotension and tardive dyskinesia (TD-a medication induced movement disorder characterized by uncontrollable, repetitive movements-primarily in the face, lips, tongue and sometimes limbs or torso), dated 2/12/2026. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 2/26/2026 at 9:25 a.m., Resident 3's medical record was reviewed. Resident 3's medical record did not contain (continued on next page)

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

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented evidence that orthostatic blood pressure monitoring had been performed since Resident 3's re-admission on [DATE] RN 1 verified and stated that orthostatic blood pressure monitoring was not performed. RN 1 stated that they have to monitor orthostatic blood pressure weekly for residents that are taking Zyprexa medication because the medication placed the resident at risk for orthostatic hypotension which can cause dizziness and increase the risk of falls. During an interview with Pharmacist (Pharm 1) on 2/26/2026 at 11:04 a.m., Pharm 1 stated she recommended weekly orthostatic blood pressure check for residents taking Zyprexa since orthostatic hypotension was one of the side effects that can cause dizziness, lightheadedness and potential for being unsteady, when getting up too quickly. During a review of facility's policy and procedures (P&P) titled, Orthostatic Blood Pressure, reviewed on 1/29/2026, the P&P indicated, Orthostatic vital signs shall be taken and recorded when ordered by the physician. During a review of facility's P&P titled, Psychotherapeutic Medications and Informed Consent, reviewed on 1/29/2026, the P&P indicated that, It is the policy of the facility that each resident will attain to and maintain his/her highest practicable well-being in an environment that limits the use of psychotherapeutic medication use to circumstance in which the resident has medical symptoms that warrant the use, as well as monitoring the frequency and duration needed to identify therapeutic effectiveness and adverse consequences. b. During a review of Resident 10's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and psychosis (a mental health symptom where a person loses touch with reality). During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 10 required setup or clean-up assistance (helper sets up or cleans us; resident completes activity) with eating. The MDS indicated Resident 10 received antipsychotic medication. During a review for Resident 10's Care Plan (CP) for Psychosis, the CP indicated a goal that Resident 10 will experience no adverse signs or symptoms of psychotropic medication. The CP indicated an intervention to monitor for side effects of olanzapine (commonly branded as Zyprexa, an antipsychotic medication to treat schizophrenia [a mental illness that is characterized by disturbances in thought and bipolar disorder [a chronic mental health condition characterized by extreme mood swings]), such as orthostatic hypotension. During a review of Resident 10's Physician's Orders, the orders indicated the following: -Olanzapine tablet 2.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) at bedtime for schizophrenia, depression (feelings of sadness), mania (mental state of an extreme highs or depressive lows), dated 5/28/2026 and discontinued 5/29/2026. -Olanzapine tablet 2.5 mg at bedtime for psychosis, manifested by sudden anger outburst as evidenced by throwing objects at staff, dated 5/28/2026. -Monitor orthostatic blood pressure for psychotropic medications, once a day on Saturday, 1. Lie supine (lie on one's back) for 3 minutes, take blood pressure, if resident can't lie supine, assist to a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	position as flat as possible; 2. Stand (or sit if unable to stand) for 3 to 5 minutes, take blood pressure; 3. If resident can remain standing, take blood pressure after 3 more minutes (or remain sitting if unable to stand) if a drop in systolic blood pressure is greater than 20 points when in an upright posture, notify physician/nurse practitioner, dated 5/28/2025 and discontinued 1/28/2026. -Monitor orthostatic blood pressure for psychotropic medications, once a day on Saturday, 1/28/2026. -Monitor orthostatic blood pressure for psychotropic medications, once a day on Saturday, 2/21/2026. 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 months of 5/2025 through 2/2026, the MARs indicated that no orthostatic blood pressures were taken from 5/28/2026 through 2/25/2026. During a review of Resident 10's Medication Regimen Review (MRR, a review by the facility's pharmacist consultant to review residents' medications and notify the facility of any errors or discrepancies in the orders) for 1/2026, dated 1/24/2026, the MRR indicated a recommendation to monitor orthostatic hypotension weekly for Resident 10 due to the olanzapine order. During an interview with the Medical Records Assistant (MRA) on 2/25/2026 at 4 p.m., the MRA stated there were no documented orthostatic blood pressures in Resident 10's MARS from 5/28/2026 until the present time (2/25/2026). During a concurrent interview and record review with the Director of Nursing (DON) on 2/25/2026 at 5:15 p.m., the DON confirmed there were no orthostatic blood pressure entries in any of Resident 10's MARs since ordered on 5/28/2026. The DON stated the licensed nurses entered the order in the electronic MAR (eMAR, electronic medication administration record) on 5/28/2026 and again on 1/28/2026 incorrectly. The DON stated the order was corrected by a licensed nurse on 2/21/2026. The DON stated it is important to monitor orthostatic hypotension by taking an orthostatic blood pressure because a resident can have lightheadedness and dizziness and be at risk for fall. During a phone interview with the facility's pharmacist (PHARM 1) on 2/26/2026 at 11:04 a.m., PHARM 1 stated orthostatic hypotension can occur for a resident on an antipsychotic medication such as olanzapine. PHARM 1 stated a resident could experience dizziness, lightheadedness, and potential for being unsteady on one's feet when they rise too quickly. PHARM 1 stated that is why she made the recommendation to take orthostatic blood pressures weekly for Resident 10 in the 1/2026 MRR. During a concurrent interview and record review with Registered Nurse 4 (RN 4) on 2/26/2026 at 3:22 p.m., RN 4 reviewed the 1/28/2026 order to measure Resident 10's orthostatic blood pressure weekly. RN 4 stated she entered the order in the eMAR because she reviewed Resident 10's MRR for 1/2026 and saw that PHARM 1 made the recommendation to take orthostatic blood pressure. RN 4 stated she entered the order incorrectly on 1/28/2026. RN 4 stated she should have checked Resident 10's eMAR to see if the order showed up as a task for the licensed nurses to complete on Saturdays. RN 4 stated it is important to monitor orthostatic blood pressure because an antipsychotic medication can cause lightheadedness and a resident could fall. During an interview with Licensed Vocational Nurse 10 (LVN 10) on 2/26/2026 at 3:29 p.m., LVN 10 stated she works the weekends on the 3 p.m. to 11 p.m. shift, the shift in which the licensed nurses conduct orthostatic blood pressure for those residents with orders. LVN 10 stated the order would (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	show in the eMAR for the licensed nurses to conduct. LVN 10 stated she does not remember taking any orthostatic blood pressures in the past for Resident 10. LVN 10 stated it is important to monitor orthostatic blood pressures because it can cause side effects such as dizziness, hypotension, which may increase the resident's risk for falls. During a review of facility's policy and procedures (P&P) titled, Orthostatic Blood Pressure, reviewed on 1/29/2026, the P&P indicated, Orthostatic vital signs shall be taken and recorded when ordered by the physician. During a review of facility's P&P titled, Psychotherapeutic Medications and Informed Consent, reviewed on 1/29/2026, the P&P indicated that, It is the policy of the facility that each resident will attain to and maintain his/her highest practicable well-being in an environment that limits the use of psychotherapeutic medication use to circumstance in which the resident has medical symptoms that warrant the use, as well as monitoring the frequency and duration needed to identify therapeutic effectiveness and adverse consequences. During a review of the facility's P&P titled, Documentation – General, last reviewed 1/29/2026, the P&P indicated that a resident's condition, including assessment findings and pertinent information related to clinical care, outcome to treatments, and changes of condition should be recorded in the medical record.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 7 of 7 sampled residents (38, 56, 57, 58, 64, 82, 84) had the Care Area Assessment (CAA) completed within the timeframe outlined on the Resident Assessment Instrument (RAI - a mandatory assessment tool used for the Centers for Medicare and Medicaid Services (CMS)). This failure had the potential to result in inadequate, non-individualized care plans, missed identification of resident risks, and potential for decline in health. Findings: a. During a review of Resident 38's Face Sheet, the Face Sheet indicated the facility admitted Resident 38 on 1/25/2024 with diagnoses that included but not limited to: sepsis (a life-threatening blood infection), metabolic encephalopathy (a brain dysfunction that can cause confusion), dementia (a progressive state of decline in mental abilities), and hypertension (elevated blood pressure). During a review of Resident 38's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/19/2026, the MDS indicated Resident 38 has severely impaired cognitive skills for daily decision making. Resident 38 needs moderate assistance (helper does less than half the effort) for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 38's CAA worksheet work history dated 1/19/2026 was reviewed. MDS 1 stated, Resident 38's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 1/19/2026. MDS 1 stated the CAA should have been completed by 2/2/2026 but was still modified on 2/23/2026. MDS 1 stated the CAA is used to identify risk factors and update the resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD. b. During a review of Resident 56's Face Sheet, the Face Sheet, indicated the facility admitted Resident 56 on 4/18/2025 to the facility with diagnoses that included but not limited to: Alzheimer's disease (a disease characterized by a progressive decline in mental abilities, dementia (a progressive state of decline in mental abilities), overactive bladder (a condition that causes frequent urges to urinate) and hypertension (elevated blood pressure). During a review of Resident 56's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/24/2026, the MDS indicated Resident 56 has severely impaired cognitive skills for daily decision making. Resident 56 is independent for eating but needs moderate to maximum assistance for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 56's CAA worksheet work history dated 4/24/2025 was reviewed. MDS 1 stated, Resident 56's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 4/24/2025. MDS 1 stated the CAA should have been completed by 5/1/2025 but was still modified on 5/21/2025. MDS 1 stated the CAA is used to identify risk factors and update the Resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD. c. During a review of Resident 57's Face Sheet, the Face Sheet indicated Resident 57 was admitted on [DATE] with diagnoses that included but not limited to: metabolic encephalopathy (a brain dysfunction that can cause confusion), dementia (a progressive state of decline in mental abilities), and urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of Resident 57's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/21/2026, the MDS indicated Resident 57 has severely impaired cognitive skills for daily decision making. Resident 57 was dependent for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 57's CAA worksheet work history dated 1/21/2026 was reviewed. MDS 1 stated, Resident 57's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 1/21/2026. MDS 1 stated the CAA should have been completed by 2/4/2026 but was still modified on 2/23/2026. MDS 1 stated the CAA is used to identify risk factors and update the Resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD. d. During a review of Resident 58's Face Sheet, the Face Sheet indicated the facility admitted Resident 58 to the facility on [DATE] with diagnoses that included but not limited to: dementia (a progressive state of decline in mental abilities), cerebrovascular accident (CVA- stroke, loss of blood flow to a part of the brain), dysphagia (difficulty swallowing), and hypertension (elevated blood pressure). During a review of Resident 58's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/23/2026, the MDS indicated Resident 58 has severely impaired cognitive skills for daily decision making. Resident 58 was dependent for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 58's CAA worksheet work history dated 10/23/2025 was reviewed. MDS 1 stated, Resident 58's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 10/23/2025. MDS 1 stated the CAA should have been completed by 11/6/2025 but was still modified on 11/25/2025. MDS 1 stated the CAA is used to identify risk factors and update the Resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD. e. During a review of Resident 64's Face Sheet, the Face Sheet indicated the facility admitted Resident 64 on 1/18/2024 with diagnoses that included but not limited to: dementia (a progressive state of decline in mental abilities), anxiety disorder, osteoporosis (weak or brittle bones due to lack of calcium and vitamin D), and breast cancer. During a review of Resident 64's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/24/2026, the MDS indicated Resident 64 has severely impaired cognitive skills for daily decision making. Resident 38 required moderate (helper does less than half the effort) to maximum (helper does more than half the effort) assistance (for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 64's CAA worksheet work history dated 1/24/2026 was reviewed. MDS 1 stated, Resident 64's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 1/24/2026. MDS 1 stated the CAA should have been completed by 2/6/2026 but was still modified on 2/25/2026. MDS 1 stated the CAA is used to identify risk factors and update the Resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD. f. During a review of Resident 82's Face Sheet, the Face Sheet indicated the facility admitted Resident 82 to the facility on 7/16/2025 with diagnoses that included but not limited to: dementia (a progressive state of decline in mental abilities), severe protein-calorie malnutrition, osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and dysphagia (difficulty swallowing). During a review of Resident 82's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/22/2026, the MDS indicated Resident 82 has severely impaired cognitive skills for daily decision making. Resident 82 required maximum assistance for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 82's CAA worksheet work history dated (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/22/2025 was reviewed. MDS 1 stated, Resident 82's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 7/22/2025. MDS 1 stated the CAA should have been completed by 7/29/2025 but was still modified on 8/18/2025. MDS 1 stated the CAA is used to identify risk factors and update the Resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD. g. During a review of Resident 84's Face Sheet, the Face Sheet indicated the facility admitted Resident 84 to the facility on 4/19/2022 with diagnoses that included but not limited to: dementia (a progressive state of decline in mental abilities), dysphagia (difficulty swallowing), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (CKD - progressive loss of kidney function). During a review of Resident 84's Minimum Data Set (MDS-a comprehensive assessment and screening tool) dated 1/17/2026, the MDS indicated Resident 84 has severely impaired cognitive skills for daily decision making. Resident 84 required moderate to maximal assistance for activities of daily living (ADL - bed mobility, dressing, toilet use, and personal hygiene). During a concurrent interview and record review on 2/25/2026 at 2:21 pm with the MDS nurse (MDS 1), Resident 84's CAA worksheet work history dated 1/17/2026 was reviewed. MDS 1 stated, Resident 84's CAA should have been completed 14 days from the Assessment Reference Date (ARD) of 1/17/2026. MDS 1 stated the CAA should have been completed by 1/30/2026 but was still modified on 2/20/2026. MDS 1 stated the CAA is used to identify risk factors and update the Resident's care plans. During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual Version 3.0, dated October 2023, the RAI indicated the CAA completion date must be done no later than 14 calendar days from the ARD.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident's pain was assessed and documented on the Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) before and after pain medication administration for one (Resident 8) of one sampled resident investigated for pain. This deficient practice had the potential to result in ineffective pain management, placing the resident at risk for unrelieved pain. Findings: During a review of Resident 8's Face Sheet (a page with information indicated for a resident such as facility admission date and pertinent diagnoses), the Face Sheet indicated the facility admitted the resident to the facility on [DATE] with diagnoses that included low back pain. During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/18/2025, the MDS indicated Resident 8 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 8 required maximal assistance (helper does more than half the effort) with eating and dressing. During a review of Resident 8's Physician's Orders, the Physician Orders indicated an order for Tramadol tablet 50 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) as needed (PRN, given as needed or requested) every 12 hours for moderate to severe (on numeric pain scale moderate pain severity is 4-6/10, with one being low pain and 10 the most excruciating pain, severe pain is 7-10 on a numeric scale) generalized pain, dated 12/15/2025. During a review of Resident 8's Controlled Drug Record (CDR, accountability record of medications that are considered to have a strong potential for abuse), the CDR indicated the medication Tramadol was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) but not documented on the 2/2026 MAR on the following dates: 2/13/2026 at 5 p.m. 2/14/2026 at 5 p.m. 2/15/2026 at 5 p.m. 2/20/2026 at 5 p.m. During a review of Resident 8's Care Plan for Pain, initiated 12/12/2025, the care plan indicated a goal that Resident 8 will demonstrate pain relief 30-60 minutes after intervention. The care plan indicated to give Tramadol as ordered and an intervention to observe for effectiveness and report unrelieved pain. During a medication cart observation and concurrent record review with Licensed Vocational Nurse 4 (LVN 4) on 2/23/2026 at 10:36 a.m., LVN 4 observed the contents of First Floor Team Cart Two medication cart. Reviewed Resident 8's CDR for Tramadol which indicated Tramadol was signed out to be given to Resident 8 on 2/13/2026 at 5 p.m., 2/14/2026 at 5 p.m., 2/15/2026 at 5 p.m., and 2/20/2026 at 5 p.m. However, there was no corresponding entry in Resident 8's 2/2026 MAR. LVN 4 verified these discrepancies. LVN 4 stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. LVN 4 stated the licensed nurse should have signed the MAR after giving the medication. LVN 4 stated this process is important so that a resident's physician knows how much medication is being given, that it is given according to the physician's ordered time frame, and will indicate whether a resident's pain relief is achieved. During an interview with the Director of Nurses (DON) on 2/23/2026 at 4:15 p.m., she confirmed that the licensed nurse that administered Tramadol on all days except for 2/17/2026 was on vacation and not available for interview. During an interview with Licensed Vocational Nurse 1 (LVN 1) on 2/26/2026 at 9:27 a.m., he stated the process for controlled drug administration is to remove the medication from the controlled drug drawer, sign the controlled drug record, give to the resident and then sign the MAR. LVN 1 stated if there is no documentation on the MAR of pain medication administration there is no record of pain assessment before or after the medication was given. LVN 1 stated this was important to access to see if a resident's pain is occurring frequently which will inform the licensed nurses in changing interventions regarding pain control. During an (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview with the Director of Nurses (DON) on 2/26/2026 at 11:31 a.m., the DON stated the process for administering controlled pain medication is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DON stated if there was no pain medication administration documented on the MAR, then the pain was not assessed for those dates and times. The DON stated it is important to sign the MAR when giving pain medication, so there is a pain level documented. The DON stated if the licensed nurse does not sign the MAR, then no assessment or reassessment of the effectiveness of the pain medication and a resident's pain relief will not be relieved. The DON stated this is needed to provide quality care for Resident 8. During a review of the facility's policy and procedure titled, Pain Management, last reviewed 1/29/2026, the policy indicated the licensed nurse shall administer PRN pain medication as ordered and document on the MAR the drug, time of administration, dose, pain scale rating and resident's/patient's response and subsequent pain scale to medication within one hour.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1.Ensure the Controlled Drug Record (CDR, accountability record of medications that are considered to have a strong potential for abuse) coincided with the Medication Administration Records (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) affecting Resident 8 for one of two medication carts (First Floor Team 2 Medication Cart) inspected. This deficient practice had the potential to result in medication error and/or drug diversion (illegal distribution or abuse of prescription drug). 2. Transcribe a physician's order onto the Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) resulting in failure to monitor a resident's orthostatic blood pressure (taking blood pressure measurements taken to detect a significant drop in blood pressure when moving from lying/sitting to standing) who was prescribed an antipsychotic medication (a medication used to treat psychosis [a mental condition in which thought and emotions are so affected that contact is lost with external reality]) for 1 (Resident 10) out of five residents investigated for unnecessary medications. This had the potential for Resident 10 to adverse effects such as lightheadedness, syncope (fainting), placing Resident 10 at risk for fall.Findings: 1.During a review of Resident 8's Face Sheet (a page with information indicated for a resident such as facility admission date and pertinent diagnoses), the Face Sheet indicated the facility admitted the resident to the facility on [DATE] with diagnoses that included low back pain. During a review of Resident 8's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 12/18/2025 the MDS indicated Resident 8 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 8 required maximal assistance (helper does more than half the effort with eating and dressing. During a review of Resident 8's Physician's Orders, the Physician's Orders indicated an order for Tramadol tablet 50 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount) as needed every 12 hours for moderate to severe generalized pain, dated 12/15/2025. During a review of Resident 8's CDR, the CDR indicated the medication Tramadol was removed from the blister pack (or called bubble pack, a card that packages doses of medication within small, clear, plastic bubbles [or blisters] that is punched out to administer to a resident) on the following dates: 2/13/2026 at 5 p.m. 2/14/2026 at 5 p.m. 2/15/2026 at 5 p.m. 2/16/2026 at 5 p.m. 2/17/2026 at 5 p.m. 2/19/2026 at 5 p.m. 2/20/2026 at 5 p.m. 2/21/2026 at 5 p.m. During a review of Resident 8's MAR for the month of 2/2026, the MAR did not indicate Resident 8 was given Tramadol on the following dates: 2/13/2026 2/14/2026 2/15/2026 2/20/2026 During a review of Resident 8's MAR for the month of 2/2026, the MAR indicated the following dates and times for Tramadol administration that the time frame was more than one hour between medication removal and administration: 2/16/2026 at 3:22 p.m. 2/17/2026 at 3:49 p.m. 2/21/2026 at 3:20 p.m. During a medication cart observation and concurrent record review with Licensed Vocational Nurse 4 (LVN 4) on 2/23/2026 at 10:36 a.m., LVN 4 observed the contents of First Floor Team Cart Two. Reviewed Resident 8's CDR for Tramadol which indicated Tramadol was signed out to be given to Resident 8 on 2/13/2026 at 5 p.m., 2/14/2026 at 5 p.m., 2/15/2026 at 5 p.m., and 2/20/2026 at 5 p.m. However, there was no corresponding entry in Resident 8's 2/2026 MAR. For the entries for 2/16/2026, 2/17/2026, and 2/21/2026 the time frame was more than one hour between medication removal and administration. LVN 4 verified these discrepancies. LVN 4 stated the process for giving controlled medications is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. LVN 4 stated the licensed nurse should have signed the MAR after giving the medication. LVN 4 stated this process is important (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	so that a resident's physician knows how much medication is being given not too soon and will indicate if a resident's pain relief is achieved. During an interview with the Director of Nurses (DON) on 2/23/2026 at 4:15 p.m., she confirmed that the licensed nurse that administered Tramadol on all days except for 2/17/2026 was on vacation and not available for interview. During a concurrent interview and record review with LVN 5 on 2/23/2026 at 4:34 p.m., LVN 5 reviewed Resident 8's Tramadol CDR and MAR for 2/2026. LVN 5 confirmed that she signed Tramadol as given on 2/17/2026 at 3:49 p.m. but the CDR reflected 2/17/2026 at 5 p.m. LVN 5 stated the process is to remove the medication from the controlled drug drawer, sign the CDR, give the medication, and sign the MAR. LVN 5 stated she was unable to recall the specifics for that day but that it is important to follow that procedure to ensure the medication is given at the right time and accurate records are maintained. During an interview and concurrent record review with the Director of Nurses (DON) on 2/26/2026 at 11:31 a.m., the DON reviewed the facility's policy and procedure titled, Controlled Substances, last reviewed 1/29/2026. The policy indicated the following: -Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following on the accountability record and the MAR: Date and time of administration (MAR, Accountability Record). Amount administered (Accountability Record). Remaining quantity (Accountability Record). Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability). The DON stated the process is that when a controlled drug is removed from the bubble pack, the licensed nurse is to sign the controlled drug record, give the medication to the resident, and then sign the MAR. The DON stated following that procedure is important to ensure there is accountability of controlled medications. The DON stated she believed the medications removed for Resident 8 and were documented on the CDRs were given to them. The DON stated if there was no documentation on the MAR, then the pain was not assessed for those dates and times. The DON stated it is important to sign the MAR after giving medication. The DON stated, for pain medication, there is a pain level documented and if the medication is not signed on the MAR, then there is no assessment or reassessment of the effectiveness of the pain medication and a resident's pain relief will not be relieved. 2. During a review of Resident 10's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities) and psychosis. During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2026, 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 required setup or clean-up assistance (helper sets up or cleans us; resident completes activity) with eating. The MDS indicated Resident 10 took an antipsychotic medication. During a review for Resident 10's Care Plan for Psychosis, the care plan indicated a goal that Resident 10 will experience no adverse signs or symptoms of psychotropic medication. The care plan indicated an intervention to monitor for side effects of olanzapine such as orthostatic hypotension.During a review of Resident 10's Physician's Orders, the orders indicated the following: - Olanzapine tablet 2.5 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount) at bedtime for schizophrenia (a mental illness that is characterized by disturbances in thought), depression (feelings of sadness), mania (mental state of an extreme highs or depressive lows), dated 5/28/2026 and discontinued 5/29/2026.- Olanzapine tablet 2.5 mg at bedtime for psychosis, manifested by sudden anger outburst as evidenced by throwing objects at staff, dated 5/28/2026.- Monitor orthostatic blood pressure for psych medications, once a day on Saturday, 1) Lie supine (lie on one's back) for 3 minutes, take blood pressure, if resident can't lie supine, assist to a position as flat as possible. 2) Stand (or sit if unable to stand) for 3 to 5 minutes, take blood pressure 3) If resident can remain standing, take blood pressure after 3 more minutes (or remain sitting if unable to stand) if a drop in systolic blood pressure (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is greater than 20 points when in an upright posture, notify physician/nurse practitioner, dated 5/28/2025 and discontinued 1/28/2026.- Monitor orthostatic blood pressure for psych medications, once a day on Saturday, 1/28/2026.- Monitor orthostatic blood pressure for psych medications, once a day on Saturday, 2/21/2026. 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 months 5/2025 through 2/2026, the MARs indicated there were no orthostatic blood pressures taken from 5/28/2026 until 2/25/2026. During a review of Resident 10's Medication Regimen Review (MRR, a review by the facility's pharmacist consultant to review residents' medications and notify the facility of any errors or discrepancies in the orders) for 1/2026, dated 1/24/2026, the MRR indicated a recommendation for Resident 10 to please monitor for orthostatic hypotension weekly for the olanzapine order. During an interview with the Medical Records Assistant (MRA) on 2/25/2026 at 4 p.m., the MRA stated there were no documented orthostatic blood pressures in Resident 10's MARS from 5/28/2026 until the present time (2/25/2026). During a concurrent interview and record review with the Director of Nursing (DON) on 2/25/2026 at 5:15 p.m., the DON confirmed there were no orthostatic blood pressure entries in any of Resident 10's MARs since ordered on 5/28/2026. The DON stated the licensed nurses imputed the order in the electronic MAR (eMAR, electronic medication administration record) on 5/28/2026 and again on 1/28/2026 incorrectly. The DON stated the order was corrected by a licensed nurse on 2/21/2026. The DON stated it is important to monitor orthostatic hypotension by taking an orthostatic blood pressure because a resident can have lightheadedness and dizziness and be at risk for fall. During a phone interview with the facility's pharmacist (PHARM 1) on 2/26/2026 at 11:04 a.m., PHARM 1 stated orthostatic hypotension can occur for a resident on an antipsychotic medication such as olanzapine. PHARM 1 stated a resident could experience dizziness, lightheadedness, and potential for being unsteady on one's feet when they rise too quickly. PHARM 1 stated that is why she made the recommendation to take orthostatic blood pressures weekly for Resident 10 in the 1/2026 MRR. During a concurrent interview and record review with Registered Nurse 4 (RN 4) on 2/26/2026 at 3:22 p.m., RN 4 reviewed the 1/28/2026 order to measure Resident 10's orthostatic blood pressure weekly. RN 4 stated she entered the order in the eMAR because she reviewed Resident 10's MRR for 1/2026 and saw that PHARM 1 made the recommendation to take orthostatic blood pressure. RN 4 stated she entered the order in the eMAR as a nursing order but should have been entered as a physician order so the orthostatic blood pressure would display in the computer to ensure the licensed nurses would have to take the orthostatic blood pressure on Saturdays. RN 4 stated she should have checked Resident 10's eMAR to see if the order showed up as a task for the licensed nurses to complete on Saturdays. RN 4 stated it is important to monitor orthostatic blood pressure because an antipsychotic medication can cause lightheadedness and a resident could fall. During an interview with Licensed Vocational Nurse 10 (LVN 10) on 2/26/2026 at 3:29 p.m., LVN 10 stated she works the weekends on the 3 p.m. to 11 p.m. shift, the shift in which the licensed nurses conduct orthostatic blood pressure for those residents with orders. LVN 10 stated the order would show in the eMAR for the licensed nurses to conduct. LVN 10 stated she does not remember taking any orthostatic blood pressures in the past for Resident 10. LVN 10 stated it is important to monitor orthostatic blood pressures because it can cause side effects such as dizziness, hypotension, and present a fall risk for residents. During a review of facility's policy and procedure titled, Orthostatic Blood Pressure, last reviewed 1/29/2026, the policy indicated, Orthostatic vital signs shall be taken and recorded when ordered by the physician. During a review of facility's policy and procedure titled, Psychotherapeutic Medications and Informed Consent, reviewed on 1/29/2026, the policy indicated that, It is the policy of the facility that each resident will attain to and maintain his/her highest practicable well-being in an environment that limits the use of psychotherapeutic medication use to circumstance in which the resident has medical symptoms that warrant the use, as well as monitoring the frequency and duration needed to identify therapeutic effectiveness and adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label and store drugs and biologicals in accordance with accepted professional principles when the facility: 1.Failed to ensure an eye drop medication was not used past the expiration date for one (First Floor Team Two Medication Cart) of two medication carts that were inspected during the survey. 2.Failed to ensure the label in the Midodrine (given for hypotension or low blood pressure) bubble pack (a method of organizing medications into individual doses, typically sealed in compartments with protective bubbles) is consistent with the physician`s order for the same medication for one of seven residents (Resident 24) observed during the medication administration task. 3. Failed to ensure prescription labels for four of seven sampled residents (Resident 6, 7, 36, and 78) with medications bearing a black box warning (warning on a medication that represents serious or life-threatening potential side effect associated with the specific medication) were labeled and identified with a black box warning per facility policy. These deficient practices had the potential to result in Resident 6,7,24, 28, 36,78 receiving medication that was ineffective, unnecessary and/or unsafe. Findings: 1.During a review of Resident 28's Face Sheet (page with information indicated for a resident such as facility admission date and pertinent diagnoses), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included glaucoma (eye never damage that can cause blindness). During a review of Resident 28's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 12/15/2025 the MDS indicated Resident 28 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 8 vision was moderately impaired, having limited vision, not able to see newspaper headlines but can identify objects. During a review of Resident 28's Physician Order Report, the Physician Order Report indicated an order for Latanoprost Ophthalmic Solution (an eye medication) 0.005%, instill one drop in both eyes once an evening for glaucoma dated 11/25/2025. During a review of Resident 28's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 2/2026 covering the dates 2/10/2026 to 2/22/2026, the MAR indicated Resident 28 received Latanoprost as ordered. During a concurrent medication cart observation and interview with Licensed Vocational Nurse (LVN) 4 on 2/23/2026, observed the First Floor Team Two medication cart. The medication cart contained Resident 28's Latanoprost eye drops with an open date of 12/29/2025. LVN 4 stated she thought eye drops can be used up until 30 days after being first opened. LVN 4 stated it is important to not use eye drops past the expiration date to ensure the medications are still effective in treating a patient's condition. During a concurrent interview and record review with the Director of Nursing (DON) on 2/26/2026 at (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:36 a.m., the DON reviewed the Latanoprost Manufacturer's Instructions, dated 2/21/2026. The DON stated, according to Latanoprost Manufacturer's Instructions, the medication is to be discarded after six weeks of opening. The DON reviewed Resident 28's 2/2026 MAR that covered the dates 2/10/2026 to 2/22/2026. The DON stated the Latanoprost should have been discarded after 2/09/2026 and verified that Resident 28 received Latanoprost 2/10/2026 through 2/22/2026. The DON stated it is important to follow the Latanoprost Manufacturer's Instructions to ensure the medication is still effective in treating Resident 28's condition. During a review of the facility's policy and procedure (P&P), titled, Storage of Medications, last reviewed 1/29/2026, the P&P indicated all expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. 2. During a review of Resident 24's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 11/20/2023 and readmitted on [DATE] with diagnosis including hypotension (abnormally low blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 24's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 24 required substantial/maximal assistance (helper does more than half the effort) from staff for activities of daily living (ADL - activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During a review of Resident 24`s Physician Order Report from 2/01/2026 to 2/24/2026, the Physician Order Report indicated an order for Midodrine 5 milligram oral tablet twice a day for hypotension and hold for systolic blood pressure (SBP-measures the maximum pressure in your arteries when the heart contracts) greater than 120 millimeters of mercury (mmHg- measurement for pressure). During a medication pass observation on 2/24/2026, observed LVN 3 take Resident 24's blood pressure which read 101/62 mmHg, with a heart rate of 61 beats per minute (bpm). LVN 3 then returned to the medication cart and began preparing Resident 24's morning medications. LVN 3 reviewed the order in the electronic medication administration record (eMAR) for Midodrine, which indicated to administer Midodrine 5 mg by mouth twice daily for hypotension and to hold the medication if the SBP was greater than 120 mmHg. LVN 3 then proceeded to administer Midodrine to Resident 24. After the medication was administered, LVN 3 was asked to retrieve the Midodrine bubble pack. Upon review, the bubble pack label read: Midodrine 5 mg tablet, give one tablet (5 mg) by mouth twice daily for hypotension, hold for systolic blood pressure less then 120 mmHg. LVN 3 there was a discrepancy between the Midodrine order in the eMAR and the order indicated on the Midodrine bubble pack, however, she stated she follows the order indicated in the eMAR and was aware that Midodrine was ordered for hypotension and should be held if the SBP is greater than 120 mmHg. During an interview and record review on 02/26/2026 at 11:09 a.m., with Registered Nurse (RN) 1, reviewed Resident 24`s electronic physician`s order for Midodrine and the bubble pack containing Midodrine. RN 1 stated that the inaccurate label was a lapse by the pharmacy. RN 1 stated that the inaccurate label can potentially cause a medication error which could cause the resident`s blood pressure to drop placing the resident at risk for dizziness, falls, and injuries.  During a review of the facility`s P&P titled Medication Labeling, last reviewed on 1/29/2026, the P&P (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated that All medication containers shall be labeled and medication labels must be clear, consistent, legible and in compliance with state and federal requirements.the licensed contracted pharmacy is responsible for dispensing and delivering meds in accordance with state and federal law. The licensed nurse will contact the pharmacy if the label is illegible or has questionable or incomplete information. 3. a. During a review of Resident 6's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 6 to the facility on [DATE], and re-admitted on [DATE] with diagnoses that included Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), major depressive disorder (a mental health condition characterized by persistent, intense, and long-lasting low mood, sadness, or loss of interest in daily activities), and acute posthemorrhagic anemia (a condition in which a person loses a large amount of blood, leading to significant drop in red blood cells that deliver oxygen to body tissues and organs). During a review of Resident 6's MDS dated [DATE], the MDS indicated Resident 6's cognitive skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated Resident 6 was dependent (Helper does all the effort) with eating, oral hygiene, toileting hygiene, personal hygiene, and upper body/lower body dressing. During a review of Resident 6's H&P completed on 4/23/2025, the H&P indicated Resident 6 does not have the decision-making capacity. During a review of Resident 6's Physician Order Report dated 2/1/2026-2/26/2026, the Physician Order Report indicated an order for Sertraline (antidepressant medication) tablet 25 mg oral at bedtime. During a concurrent observation and interview and record review with LVN 4, on 2/26/2026 at 12:20 p.m., observed Resident 6's Sertraline bubble pack without a black box warning label. During a review of Resident 6's Medication Administration Record (MAR) dated 2/1/2026 - 2/26/2026, the MAR did not indicate a black box warning for Sertraline. LVN 4 stated Sertraline should have a black box warning because it is a psychotropic drug (substance that alter brain function, affecting mood, perception, consciousness, and behavior). LVN 4 further stated a black box warning on the bubble pack warns the nurse that the medication has adverse side effects to be especially aware of, and possibly specific monitoring required which makes the label important for resident safety. b. During a review of Resident 36's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 36 to the facility on [DATE], and was re-admitted on [DATE] with diagnosis that included Alzheimer's disease, major depressive disorder, and bipolar disorder (mental health condition that causes extreme, long-lasting shifts in mood, energy, activity level and concentration). During a review of Resident 36's MDS dated [DATE], the MDS indicated Resident 36's cognitive skills for daily decision making was severely impaired. The MDS indicated Resident 36 was dependent with eating, oral hygiene, toileting hygiene, personal hygiene, shower/bath self, and upper body/lower body dressing. During a review of the H&P report completed on 4/23/2025, the H&P indicated Resident 36 does not have decision making capacity. During a review of Resident 36's Physician Order Report dated 2/1/2026-2/26/2026, the Physician (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order Report indicated an order for Remeron (antidepressant medication) tablet 7.5mg milligrams oral once an evening. During a concurrent observation, interview and record review with LVN 4, on 2/26/2026 at 12:20 p.m., observed Resident 36's Remeron bubble pack without a black box warning label. During a review of Resident 36's Medication Administration Record (MAR) dated 2/1/2026 - 2/26/2026, the MAR did not indicate a black box warning for Remeron. LVN 4 stated Remeron should have a black box warning because it is a psychotropic drug. LVN 4 further stated a black box warning on the bubble pack warns the nurse that the medication has adverse side effects to be especially aware of, and possibly specific monitoring required which makes the label important for resident safety. c. During a review of Resident 78's Face Sheet, the Face Sheet indicated the facility originally admitted Resident 78 to the facility on 4/30/2025 and was re-admitted on [DATE] with diagnosis that included Alzheimer's, depression, and history of falling. During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 sometimes makes self-understood and sometimes able to understand others. The MDS indicated Resident 78 was dependent with upper dressing, lower dressing, tub/shower transfer, and partial/moderate assist with oral hygiene, toileting hygiene, personal hygiene and requires setup or clean-up assistance with eating. During a review of Resident 78's Physician Order Report dated 2/1/2026-2/26/2026, the Physician Order Report indicated an order for Lexapro (antidepressant medication) tablet 5 mg oral once a day. During a concurrent observation, interview and record review with LVN 4, on 2/26/2026 at 12:20 p.m., observed Resident 78's Lexapro bubble pack without a black box warning. During a review of Resident 78's MAR dated 2/1/2026 - 2/26/2026, the MAR did not indicate a black box warning for Lexapro. LVN 4 stated Lexapro should have a black box warning because it is a psychotropic drug. LVN 4 stated a black box warning on the bubble pack warns the nurse that the medication has adverse side effects to be especially aware of, and possibly specific monitoring required which makes the label important for resident safety. d. During a review of Resident 7's Face Sheet, Face Sheet indicated Resident 7 was originally admitted on [DATE], and was re-admitted on [DATE] with diagnoses including Alzheimer's disease, atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls) and hypothyroidism (a condition in which the thyroid gland [a gland that controls hormones in the body] does not produce enough thyroid hormone). During review of Resident 7's MDS, dated [DATE], MDS indicated Resident 7 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and maximal assistance (helper does more than half of the effort) to dependent from staff for ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS also indicated Resident 7 was receiving high-risk drug medications such as antipsychotic (medication to treat psychosis [mental disorder]), antianxiety (sedatives [slow down brain activity] and medication to manage anxiety) and antidepressant medications (medications to treat depression, anxiety and chronic pain). During a review of Resident 7's Physician Order Report, the Physician Order Report indicated the following orders: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Zyprexa (antipsychotic medication) 2.5 mg by mouth twice a day, dated 3/27/202 -Mirtazapine (antidepressant medication) 7.5 mg by mouth at bedtime, dated 11/5/2025. During an observation of Resident 7's 's Zyprexa and Mirtazapine bubble packs on 2/26/2026 at 9:35 a.m., both medications did not have a black box warning label. During an interview with Pharmacist (Pharm 1) on 2/26/2026 at 2:21 p.m., Pharm 1 stated that it is important for the staff to be alerted for black box warning associated with medication usage. Pharm 1 also stated that the word black box warning will be indicated in the medication label for medication that has a black box warning, and staff can retrieve up-to-date medication warnings information through the facility's online portal. Pharm 1 stated and verified that both Zyprexa and Mirtazapine were supposed to be labeled with, black box since both medications carry black box warnings. During a review of facility's policy and procedures (P&P) titled, Black Box Warning Medications, reviewed on 1/29/2026, the P&P indicated, Facility to identify and emphasize the need for monitoring for all medications bearing a black box warning. P&P also indicated that Medications bearing a black box warning must be identified and prescription labels shall identify medications with a black box warning. During a review of facility's P&P titled, Psychotherapeutic Medications and Informed Consent, reviewed on 1/29/2026, the P&P indicated that, It is the policy of the facility that each resident will attain to and maintain his/her highest practicable well-being in an environment that limits the use of psychotherapeutic medication use to circumstance in which the resident has medical symptoms that warrant the use, as well as monitoring the frequency and duration needed to identify therapeutic effectiveness and adverse consequences.

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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. Based on observation, interview, and record review the facility failed to prevent the potential for cross-contamination when: 1.Dry goods (peanuts) were not stored in a sealed container. 2.Canned goods with dents and compromised seals were not inspected or discarded. 3.Residual food debris was not cleaned on vegetable dicers. 4.The disc blade for food processor machine was in disrepair 5.Personal belongings and potential contaminants were kept in are intended for sanitized and clean cookware This deficient practice has the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in all medically compromised residents and may also introduce chemical and physical contaminants in food being served to all residents. Findings: 1.During an observation on 2/23/2026 at 8:40 AM in the dry storage area an open cardboard box with no cover contained one clear plastic bag of peanuts that had been punctured and contained the equivalent of approximately half cup of loose individual peanuts at the bottom of the box. During an interview on 2/24/2026 at 12:50 PM with the Dietary Services Manager (DSM), the DSM stated that dry foods should be covered and sealed to maintain freshness, prevent contamination, and reduce potential vectors for pests. During a review of the facility's policies & procedures (P&P) titled, General Sanitation, reviewed on 1/29/2026, the P&P indicated that all kitchen area shall be kept clean and protected from rodents, roaches, flies, and other insects. During a review of the 2022 FDA Food Code section 3-302.11, it indicated that food is required to be protected from contamination by storing in packages, covered containers, or wrappings. 2. During an observation on 2/23/2026 at 8:45 AM in the dry storage area, three cans of mandarin oranges, one can of beets, and one can of strawberry preserves with dents were held among regular inventory of all canned goods. One can of mandarin oranges had a label that appeared soaked and stained by a liquid. During an interview on 2/24/2026 at 12:45 PM, with the DSM, the DSM stated that cans are subject to inspection upon delivery and should be discarded or returned to vendor prior to being stocked. Upon discovery of multiple dented cans, the DSM called for kitchen staff to inspect all cans and discard or set aside compromised cans. The DSM stated that dented cans may be a sign of compromised integrity and may promote foodborne illness. During a review of the 2022 FDA Food Code section 3-201.11, it indicated that food in hermetically (airtight sealed) sealed containers that are swelled or leaking to be adulterated and that dented cans may also present a serious potential hazard. 3. During an observation on 2/23/2026 at 9:00 AM in the kitchen preparation area, contained a rack with one disc blade (a circular metal attachment for food processors) with off-white fibers wedged into the corners of the blade, one disc blade with white colored debris, one grid attachment (a metal grid used to dice vegetables) with dried, white fibrous debris. During a concurrent observation in the same area a manual vegetable dicer (a countertop device with a hand-held plunger which pushes food through a metal grid to create unform cuts) contained several pieces of dried, white debris on both the grid and plunger. During a concurrent interview, the DSM stated that blades should be cleaned more thoroughly to prevent potential contaminants of food prepared in the kitchen. During a review of the facility's P&P titled General Sanitation, reviewed on 1/29/2026, the P&P indicated that all utensils and equipment shall be kept clean, maintained in good repair and shall be free from breaks and cracks and chipped areas that may affect their use or proper cleaning. Equipment such as food processors, blenders and slicers are cleaned and sanitized between uses. During a review of the 2022 FDA Food Code section 4-601.11(A), it indicated that equipment food-contact surfaces and utensils shall be clean to sight and touch. 4. During an observation on 2/23/2026 at 9:00 AM in the kitchen preparation area, contained a rack with one disc blade with a torn or chipped piece resulting in an individual jagged edge protruding from the blade and had curled to a sharp tip. During a concurrent interview with the DSM, the DSM stated, this is not acceptable and agreed that tip could fall into food and pose a physical contaminant in food prepared in the kitchen. The DSM stated a third-party (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	company services their blades and repairs are made upon request; however, the DSM was unable to provide service records to support the observation. During a review of the facility's P&P titled General Sanitation, reviewed on 1/29/2026. the P&P indicated that all utensils and equipment shall be kept clean, maintained in good repair and shall be free from breaks and cracks and chipped areas that may affect their use or proper cleaning. Equipment such as food processors, blenders and slicers are cleaned and sanitized between uses. During a review 2022 FDA Food Code section 4-202.11, it indicated multiuse food-contact surfaces shall be smooth, free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections, and free of sharp internal angles, corners, and crevices. 5. During an observation on 2/23/2026 at 1:45 PM, a sealed, metal water canteen was on a rack where clean pots and pans were held. During a concurrent observation, a pair of long, yellow rubber gloves were hanging off the rack and in contact with clean and sanitized pans. During a concurrent interview with Dietary Supervisor 1 (DS1), DS 1 stated the gloves are used for dishwashers due to harsh chemicals. DS1 stated that the canteen is a personal belonging of one of the kitchen staff members and that both the water canteen and gloves should not be kept there due to the risk of cross-contamination. During a concurrent interview, the DSM stated that staff should be leaving their personal belongings in the break room. During an observation on 2/23/2026 at 1:50 PM, a paper cup with no lid, containing liquid inside was on a shelf directly above the sanitized/clean are above a three-compartment dishwashing station (a dishwashing procedure designed to clean, rinse, and sanitize dishes, pots, and pans). During a concurrent observation, a soiled white rag was left in the sanitized/clean area where a steel pan and drying pan were left to air dry while the dishwashing station was not in use. During a concurrent interview, DS1 stated that the paper cup is a drink belonging to an unknown kitchen staff member and that the cup and soiled rag should not be in the clean area and poses a risk to cross contamination while in the sanitized area of dishwashing station. During a review of the facility's P&P titled Handling Clean Equipment and Utensils, reviewed on 1/29/2026, the P&P indicated that clean and sanitized equipment and utensils should be stored in a clean, dry location so that food contact surfaces are protected from splash, dust, and other contaminants. During a review of the facility's P&P titled General Sanitation, reviewed on 1/19/2026, the P&P indicated that fabric wiping clothes will be used once and stored in container of appropriately concentrated quaternary sanitizing solution or stored in an appropriate bin designated for laundering. During a review of the 2022 FDA Food Code section 3-3401.14(D), it indicated that wiping clothes shall be free of food debris and visible soil. During a review of the facility's P&P titled General Sanitation, reviewed on 1/19/2026, the P&P indicated that the DSM will be responsible for scheduling for regular cleaning of kitchen and dining areas and that dietary staff will maintain cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment. During a review of the facility's P&P titled General Infection Control, reviewed on 1/19/2026, the P&P indicated that beverages for hydration purposes are allowed away from food preparation areas unless in a cup with lid and straw or canister with spout to prevent spillage. During a review of the 2022 FDA Food Code section 2-401.11(B) it indicated that a food employee may drink from a closed beverage container if the container is handled to prevent contamination of clean equipment.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the binding arbitration agreement (Arbitration Agreement, a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship, whether contractual or not. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) was explained to residents' representatives in a form and manner that he or she understands for 4 (Resident 10, Resident 16, Resident 33, Resident 68) of 4 sampled residents. This had the potential for residents' rights to not be honored. Findings: a. During a review of Resident 10's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities). During a review of Resident 10's Minimum Data Set (MDS, a resident assessment tool), dated 1/27/2026, 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 required setup or clean-up assistance (helper sets up or cleans us; resident completes activity) with eating. During a review of Resident 10's Arbitration Agreement, the document indicated Family Member of Resident 10 (FM10) signed the agreement on 1/17/2025. b. During a review of Resident 16's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 16 required setup or clean-up assistance with eating. During a review of Resident 16's Arbitration Agreement, the document indicated FM16 signed the agreement on 12/23/2025. c. During a review of Resident 33's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia. During a review of Resident 33's MDS, the MDS indicated Resident 33 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 33 required supervision (helper provides verbal cues as resident completes activity) with eating. During a review of Resident 33's Arbitration Agreement, the document indicated FM33 signed the agreement on 1/27/2026. d. During a review of Resident 68's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included dementia. During a review of Resident 68's MDS dated [DATE], the MDS indicated Resident 68 was severely impaired in cognition with skills required for daily decision making. The MDS indicated Resident 68 required supervision with eating. During a review of Resident 68's Arbitration Agreement, the document indicated FM68 signed the agreement on 1/26/2026. During a telephone interview with FM10 on 2/24/2026 at 11:16 a.m., she stated she wanted a copy of Resident 10's Arbitration Agreement. FM10, stated she was unaware of the document. FM10 stated she was asked to sign some admission paperwork and was told she needed to sign them for Resident 10 to be admitted to the facility. FM10 stated she signed the documents electronically and the documents went back to the facility. During a telephone interview with FM68 for 2/25/2026 at 10:17 a.m., she stated she did not know what an arbitration agreement was but to call FM68B who might be more knowledgeable of the arbitration agreement. Called FM68B on 2/24/2026 at 10:25 a.m. who stated he wanted a copy of Resident 68's Arbitration Agreement and wanted to find out more about the document. FM68B stated he was not aware the facility offered an arbitration agreement. During a telephone interview with FM33 on 2/25/2026 at 10:38 a.m., she stated she wanted a copy of Resident 33's Arbitration Agreement. FM33, stated she did not know what the document was because at the time of admission, she was asked to sign admission paperwork before Resident 33 was to be admitted to the facility. FM33 stated she signed (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the documents electronically and the documents were transmitted to the facility. During a telephone interview with FM16 on 2/25/2026 at 11:16 a.m., she stated she wanted a copy of Resident 10's Arbitration Agreement. FM16, stated she was unaware of the document. FM16 stated she was asked to sign some admission paperwork and was told she needed to sign them for Resident 16 to be admitted to the facility. FM16 stated she signed the documents electronically without asking questions. During an interview with the Admissions Director (ADIR) on 2/25/2026 at 11:30 a.m., she stated she would contact the family members of Resident 10, 16, 33, and 68. The ADIR stated the arbitration agreement is emailed with the admission packet and if the family has questions, they will give the facility a call and ask questions. The ADIR stated the Admissions Department explains the arbitration process only if the family has questions. During a concurrent interview and record review with the ADIR and Admissions Assistant (AASSIST) on 2/26/2026 at 11 a.m., they reviewed a sample of admission Paperwork. The AASSIST stated the process is that she scans the documents which includes the admission paperwork and arbitration agreement. The AASSIST stated these documents are transmitted in one email to residents' families, the family opens and reviews the documents, then clicks in the signature area to sign. The AASSIST stated a form must be signed before moving to the next document. The AASSIST stated if the responsible party does not sign a document, the system does not let them complete the signing process. The AASSIST displayed a copy of the paperwork that is sent to residents' responsible parties. The arbitration agreement was located in the middle of the paperwork. The AASSIST stated there is no particular order for documents to be sent in and the arbitration agreement is not separate from the admission documents. During the same interview, the ADIR and AASSIST reviewed the facility's policy and procedure titled, Arbitration, last reviewed 1/29/2026 which indicated: The arbitration agreement Must be separate from the admission agreement. Must be clearly labeled as Voluntary Arbitration Agreement. Must not be embedded within admission paperwork. Admissions staff shall verbally explain: Arbitration is voluntary. Signing is not required for admission or continued care. Reside3nt has the right to consult an attorney. Resident may rescind within 30 days (recommended best practice). The ADIR and AASSIST confirmed that they do not follow the above practices. The ADIR and AASSIST stated they verbally explain the arbitration agreement only when a resident's family asks questions. The ADIR stated it is important for residents' families to know what the arbitration agreement is, in the case that if they may want to sue, they can be aware of the processing of proceeding through court or arbitration. During a concurrent interview with the Administrator (ADM) on 2/26/2026 at 10:46 a.m. she stated it is residents' families' right to know about the arbitration agreement before signing. The ADM stated she will be examining the arbitration agreement notification process to ensure residents' families know what the arbitration agreement is before signing. ˆ

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident`s dignity and respect by failing to ensure a licensed nurse knocked prior to entering a resident`s room for one of seven residents (Resident 24) observed during medication administration task. This deficient practice violated the resident's right to be treated with respect and dignity and had the potential to affect Resident 24`s sense of self-worth and self-esteem. Findings: During a review of Resident 24's admission Record, the admission Record indicated the facility originally admitted the resident on 11/20/2023 and readmitted on [DATE] with diagnosis including hypotension (abnormally low blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 24's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 11/13/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 24 required substantial/maximal assistance (helper does more than half the effort) from staff for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During a concurrent medication pass observation and interview on 2/24/2026, observed Licensed Vocational 3 sanitized her hands, obtained blood pressure machine from the medication cart and entered the Resident 24`s room and proceeded to the resident`s bedside, without knocking on the door prior to entry. After taking the resident's blood pressure, LVN 3 returned to the medication cart and began preparing the resident's morning medications. During an interview, LVN 3 stated that she should have knocked prior to entering Resident 24's room as a sign of respect for the resident's private space. LVN 3 further stated that the resident's dignity and privacy should be promoted at all times. During a review of the facility`s policy and procedure (PP) titled Residents/Patient Dignity and Privacy, last reviewed on 1/29/2026 , the PP indicated that The facility provides care for residents/patients in a manner that respects and enhances each resident/patient`s dignity, individuality, and right to personal privacy.knock on doors before entering; announce your presence.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and record review, the facility failed to promote resident rights to examine the results of the most recent survey (a survey to determine compliance with state and federal regulations) of the facility by failing to post reports with respect to any surveys, certifications, and complaint investigations made during the three preceding years, and any plan of correction in effect with respect to the facility, in areas of the facility that are prominent and accessible to the public. This deficient practice had the potential to impede residents' rights and can negatively affect residents' psychosocial wellbeing. Findings: During an observation on 2/25/2026 at 2:13 p.m., survey results binder 2 was observed in the corner wall of the second-floor dining room. Survey results binder 2 indicated the facility's last survey was conducted on 3/6/2025. During an observation on 2/25/2026 at 2:16 p.m., survey results binder 1 was observed in the corner wall of the first-floor dining room. Survey results binder 1 indicated the facility's last survey was conducted on 3/6/2025. During the resident council task meeting interview on 2/24/2026 at 11:06 a.m., five of five residents (Resident 10, 20, 24, 32 and 53) stated that they were not aware of the most recent survey results and where it was located. During an interview with the Administrator (ADM) on 2/26/2026 at 10:49 a.m., the ADM stated that surveys had been conducted after 3/6/2025 and the facility is responsible for updating the survey results binders whenever a survey is conducted. The ADM stated that is important for staff, residents and their families to be aware of facility's status regarding compliance with the regulations and any areas of concerns or deficiencies. The ADM stated that the survey results binder serves as a means of open communication to ensure everyone is informed of the facility's current compliance status. During a review of facility's policy and procedures (P&P) titled, Administrative Manual, reviewed on 1/29/2026, the P&P indicated, Most recent licensing visit report (survey)/complaint investigations, and the related follow-up plan of correction visit, in areas of the facility that are prominent and accessible to the public have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review.

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	02/26/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement a comprehensive care plan that meets the resident's assessed needs for one of seven sampled residents (Resident 3) by failing to ensure orthostatic blood pressure was monitored and implemented in accordance with the physician's order. This deficient practice had the potential to have negatively impact Resident 3's health and safety, as well as the quality of care and services provided to the resident. Findings: During a review of Resident 3's Face Sheet, the Face Sheet indicated Resident 3 the facility originally admitted the resident on 2/18/2019, and re-admitted the resident on 2/11/2026 with diagnoses including syncope (fainting or passing out), dementia (loss of cognitive functioning-thinking, remembering, and reasoning) and chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure). During review of Resident 3's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 11/21/2025, the MDS indicated Resident 3 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and maximal assistance (helper does more than half of the effort) to dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 3's Physician Order Report, the Physician Order Report indicated an order dated 2/11/2026 for Zyprexa (antipsychotic medication-medication to treat psychosis [mental disorder]) 2.5 milligrams (mg) by mouth twice a day. The Physician Order Report also indicated an order to monitor Zyprexa use: once per shift to monitor behavior and monitor side effects of the following: sedation, weight gain, cardiac arrythmias (heart rate abnormalities), anticholinergic effects (constipation, dry mouth, blurred vision, urinary retention [inability to fully empty bladder]), EPS (extrapyramidal symptoms-involuntary, uncontrollable muscle movements or restlessness), headache, agitation, dizziness, orthostatic hypotension (sudden, temporary drop in blood pressure) and tardive dyskinesia (TD-a medication induced movement disorder characterized by uncontrollable, repetitive movements-primarily in the face, lips, tongue and sometimes limbs or torso), dated 2/12/2026. During a review of Resident 3's Care Plan (CP) on behavioral symptoms related to psychotic disorder with delusions (false beliefs that a person strongly believes are true when there is clear evidence that they are not true) due to dementia, dated 2/17/2026, the CP indicated that Resident 3 will have no adverse effect (harmful, unintended, or unexpected reactions caused by a medication, treatment or procedure) using a psychotropic medication. The CP approach indicated to monitor the following Zyprexa use side effects: sedation, weight gain, cardiac arrythmias, anticholinergic effects (constipation, dry mouth, blurred vision, urinary), EPS, headache, agitation, dizziness, and orthostatic hypotension every shift. During a concurrent interview and record review with Registered Nurse 1 (RN 1) on 2/26/2026 at 1:31 p.m., Resident 3's medical record including care plans were reviewed. RN 1 stated Resident 3's care was not implemented because the medical record did not contain documented evidence that orthostatic blood pressure monitoring had been performed since Resident 3's re-admission on [DATE]. RN 1 also stated that it is important to implement Resident 3's care plan interventions to ensure the resident's safety because medication places the resident at risk for orthostatic hypotension which can cause dizziness and increase the risk of falls. During a review of facility's policy and procedures (P&P) titled, Orthostatic Blood Pressure, reviewed on 1/29/2026, the P&P indicated, Orthostatic vital signs shall be taken and recorded when ordered by the physician. The P&P also indicated, Facility will develop an individualized care plan to address issues related to orthostatic hypotension. During a review of facility's P&P titled, Care Plans-Comprehensive, reviewed on 1/29/2026, the P&P indicated that the Facility will develop an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mental and psychological needs for each resident. The P&P also indicated that, The interdisciplinary team will review the attending physician's order and implement a nursing care plan to meet the resident's immediate care needs.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 24) was free from any significant medication errors by failing to administer Midodrine (a medication that increases blood pressure; used for residents with consistently low blood pressure) within the physician's prescribed parameters (specific instructions or limits set by a physician for how a medications should be given. Parameters may include when to give the medication or when to hold it). This deficient practice had the potential to cause complications such as dizziness, syncope (fainting) and possible hospitalization. Findings: During a review of Resident 24's admission Record, the admission Record, indicated the facility originally admitted the resident on 11/20/2023 and readmitted on [DATE] with diagnoses including hypotension (abnormally low blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 24's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 11/13/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 24 required substantial/maximal assistance (helper does more than half the effort) from staff for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During a review of Resident 24`s Physician Order Report from 2/01/2026 to 2/24/2026, the Physician Order Report indicated an order for Midodrine five (5) milligram (mg-unit of measurement) oral tablet twice a day for hypotension and hold for systolic blood pressure (SBP-measures the maximum pressure in your arteries when the heart contracts) greater than 120 millimeters of mercury (mmHg- a unit of pressure). During a concurrent interview and record review on 02/26/2026 at 11:09 a.m., with Registered Nurse 1 (RN 1), Resident 24`s Medication Administration Record (MAR- used to document medications taken by each individual) for February 2026 and Midodrine bubble pack (a method of organizing medications into individual doses, typically sealed in compartments with protective bubbles) were reviewed. RN 1 stated that on 2/23/2026 at 4:30 p.m., Resident 24`s blood pressure was 110/56 mm Hg. However, the Midodrine dose scheduled for 2/23/2026 at 4:30 p.m., remained in the bubble pack, and the MAR indicated that the medication was held, indicating the medication was not administered to the resident. RN 1 stated that Midodrine should have been administered to the resident since the SBP was below 120 mm Hg as indicated in the physician`s order. RN 1 stated not administering Midodrine constitutes a medication error. RN 1 stated that failure to administer Midodrine as ordered could cause the resident's blood pressure to remain low which may result in dizziness and increase the resident's risk for falls. During a review of the facility`s policy and procedure (PP) titled Medication Administration, last reviewed on 01/29/2026, the PP indicated that Medications must be administered in a timely manner and in accordance with the attending physician`s written/verbal orders.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program (coordinated effort to ensure that antibiotics are prescribed appropriately, only when needed, in the correct dose, and for the right duration) for one of two sampled residents (Resident 26) by failing to ensure the resident's physician was notified when the resident who was prescribed an antibiotic did not meet the criteria for Skin and Soft Tissue infection (SSTI- bacterial, viral, or fungal infections that occur when germs enter breaks in the skin causing pain, swelling, redness, and warmth). This deficient practice had the potential for Resident 26 developing antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 26's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted Resident 26 to the facility on [DATE] with diagnosis that included dementia (a condition characterized by decline in mental ability such as memory, reasoning and communication), Parkinsons disease (a progressive, long-term brain disorder that primarily affects movement, causing shaking, stiffness, and slow jerky motions), and major depressive disorder (a mental health condition characterized by persistent, intense, and long-lasting low mood, sadness, or loss of interest in daily activities). During a review of Resident 26's Minimum Data Set (MDS - a resident assessment tool), dated 12/2/2025, the MDS indicated Resident 26 can make self-understood and able to understand others. The MDS indicated the resident required partial/moderate (helper does less than half the effort in most areas of activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). During a review of the History and Physical (H&P) report completed on 12/01/2025, the H&P indicated Resident 26 is able to make her own needs known and able to make own medical decisions. During a review of Resident 26's Prescription Order dated 2/21/2026, the Prescription Order indicated a physician order for erythromycin ointment 5 milligrams (mg - a unit of weight)/gram (0.5%); amount: thin layer; ophthalmic (eye) twice a day, for diagnosis of blepharitis (eyelid inflammation). During a review of Resident 26's Medication Administration Record (MAR) dated 2/1/2026-2/26/2026, the MAR indicated erythromycin ointment 5mg/gram (0.5%); amount: thin layer; ophthalmic (eye) was administered on 2/21/2026 for 3:00 p.m.-11:00 p.m., on 2/22/2026 - 2/26/2026 for 7:00 a.m.- 3:00 p.m. and 3:00 p.m.-11:00 p.m. During a concurrent interview and record review on 2/26/2026 at 9:28a.m., with the Infection Preventionist Nurse (IPN), Resident 26's Infection Surveillance Checklist dated 2/21/2026 and progress notes were reviewed. The IPN stated that the checklist indicated the Skin and Soft Tissue Infection (SSTI) criteria was not met. The IPN stated she did not notify the physician that Resident 26 did not meet the SSTI criteria. The IPN stated the physician should be notified when the criteria are not met and that the notification should be documented in the resident's medical record. The IPN stated there is no documentation found in Resident 26's progress noted that the physician was notified by any member of the health care team. The IPN stated that not reporting to the physician when criteria are not met puts the resident at risk for not receiving proper treatment. During an interview on 2/26/2026 at 2:11 p.m. with the Director of Nursing (DON), the DON stated that the antibiotic review is conducted as soon as physician orders antibiotics for the resident using the Infection Surveillance Checklist. The DON stated the checklist is completed to determine whether the criteria for infection are met or not met. The DON stated the ordering physician should be notified when the criteria are not met. The DON stated that notification of the physician should be documented in the resident's medical record because if it was not documented, it cannot be confirmed that it was completed. The DON stated that if antibiotic stewardship is not properly followed, it may result in the resident receiving unnecessary antibiotics. During a review of the facility's P&P titled, Documentation - General, reviewed on 1/29/2026, the P&P indicated, Meaningful and informative notes shall be written in the residents' chart by staff to reflect the care and treatment, observations and (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessments, medications given and other appropriate entries. During a review of the facility's P&P titled, Antimicrobial Stewardship, last reviewed 1/29/2026, the P&P indicated, Key objectives include reducing inappropriate antibiotics use, improving patient/resident care outcomes and mitigating adverse consequences of antimicrobial use (i.e. antimicrobial resistance, preventable harm and unnecessary costs associated with pharmaceutical expenses and drug-resistant infections).Prescribers of the facility are expected to prescribe antibiotic therapy according to the following principles.I. The prescribing of antibiotics will be based on the best available evidence in accordance with the facility. Empirical antibiotic therapy or prophylactic therapy is prescribed according to the facility guidelines/antibiogram.If a patient/resident is prescribed antibiotic therapy that is not in accordance with the guideline/chart, the prescriber is expected to document their clinical reasoning in the patient/resident's chart/electronic record.Monitoring, Tracking, and Reporting of Antimicrobial Usage and Restrictions.e. The Infection Preventionist will be responsible for infection surveillance and Multi-drug-resistant organism (MDRO) tracking.