

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055034	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2026
NAME OF PROVIDER OR SUPPLIER Motion Picture and T.V. Hosp D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 23388 Mulholland Dr. Woodland Hills, CA 91364	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards for four of eight sampled residents (Resident 5, 35, 67, 96) reviewed for accidents by failing to: 1. Ensure Resident 5's bilateral (both sides) fall mats (a protective, impact-absorbing cushion placed on the floor alongside a patient's bed) were provided per plan of care and physician's orders when the right-side fall mat was not in place. 2. Ensure floor mats designed to reduce injury from falls, were free from objects over the mats for Residents 67 and Resident 96. These failures had the potential to result in resident falls resulting in injuries like fractures (broken bones) and lacerations for Residents 5, 67, and 96. 3. Ensure a color-coded identification strip was placed to Resident 35's picture on the door, as part of the facility's fall risk identifier for the residents. This failure had the potential to result in negative outcomes by omitting preventative measures and not identifying Resident 35 who was at risk for fall which can increase likelihood of falls resulting in severe injuries. Findings: 1. During a review of Resident 5's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 12/15/2022. During a review of Resident 5's History and Physical (H&P), dated 8/31/2025, the H&P indicated the resident's most recent admission was 9/6/2023 with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic pain, and depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 5's Minimum Data Set (MDS &ndash; resident assessment tool) dated 5/5/2026, the MDS indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated that the resident was dependent on staff for eating, oral and personal hygiene, toileting, bathing, mobility and dressing. During a review of Resident 5's Physician Orders, the Physician Orders indicated orders for the following: - Beveled Floor Mat, place beveled floor mat on both sides of bed when resident is in bed, may be removed and stored when resident is out of bed. Indication: provide comfort and reduce impact from fall, dated 4/16/2026. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 5's Care Plan (CP) regarding the resident is at risk for fall related to Parkinson's, dementia . impaired vision and hearing, immobility, and poor safety judgment, dated 9/6/2023. The CP indicated a goal that the resident would be free of fall and complication with interventions that included to place beveled mats on both sides of the bed when the resident is in bed to provide comfort and reduce impact from fall, mat may be removed and stored when the resident is out of the bed. During an observation on 7/13/2026 at 3:41 p.m., observed Resident 5, in bed awake. Observed a fall mat placed on the floor on the left side of the bed. Observed no fall mat on the floor on the right side of the bed. During an observation on 7/16/2026 at 7:33 a.m., observed Resident 5, in bed asleep. Observed a fall mat placed on the floor on the left side of the bed. Observed no fall mat on the floor on the right side of the bed. During an observation on 7/16/2026 at 10:05 a.m., observed Resident 5, in bed awake while Licensed Vocational Nurse (LVN) 6 administered medications to the resident. Observed a fall mat placed on the floor on the left side of the bed. Observed no fall mat on the floor on the right side of the bed. During a concurrent observation and interview on 7/16/2026 at 3:55 p.m., in the hallway outside Resident 5's room, with Certified Nursing Assistant (CNA) 5, CNA 5 stated Resident 5 was at risk for falls and had fall mats on both sides of the bed. Observed CNA 5 entered Resident 5's room and stated there was only a fall mat on the left side of the resident's bed and there were no other fall mats in the room. During a concurrent interview and record review on 7/16/2026 at 4 p.m., in the MP [NAME] Nursing Station, with LVN 7, reviewed Resident 5's orders and CPs. LVN 7 stated fall mats are used to prevent injury when a resident falls. LVN 7 stated he was caring for Resident 5 and the resident had orders and CPs for bilateral fall mats, so bilateral fall mats should be in place, but the right side was not there. During a concurrent interview and record review on 7/17/2026 at 2:05 p.m. with the Clinical Supervisor (CS), reviewed the facility policy and procedures (P&P) regarding fall prevention and accident prevention. The CS stated fall mats are used in the facility for residents at risk of falling to reduce the impact of a fall when it occurs. The CS stated the interdisciplinary team (IDT) determined that Resident 5 needed bilateral fall mats and the resident had an order to provide the mats and monitor that they were in place. The CS stated if the staff determined that the resident did not have a need for bilateral floor mats then the IDT should have discussed it, but they did not. The CS stated the facility P&P was not followed when Resident 5 did not have a fall mat on the right side of the bed potentially resulting in injury from falls. During a review of the facility P&P titled, Accident Prevention, approved 12/4/2025, the P&P indicated, POLICY STATEMENT: To ensure the environment is as free as possible from accident hazards and identify residents who require supervision and/or assistive devices to prevent accidents. II. PROCEDURE: . A. Identify Types of Accident Hazards, including: . Falls. 8. Ongoing Environment of (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/13/2026, with diagnoses including dementia (a progressive state of decline in mental abilities), hypertension (HTN, high blood pressure), and hard of hearing. During a review of Resident 35's MDS, dated [DATE], the MDS indicated that the resident had severe cognitive impairment (a serious decline in mental capacity affecting memory, reasoning and orientation). The MDS also indicated that Resident 35 needs partial/moderate assistance (helper does less than half the effort) with eating, transfers or repositioning, and substantial/maximal assistance with oral, toileting and personal hygiene. During a review of Resident 35's Care Plan dated 5/13/2026, titled Resident is at risk for fall related to dementia as evidenced by fourteen or greater on Fall Assessment, psychotropic or sedating medications, impaired vision, hearing, communication, (.), use of mobility devices, and poor safety judgement with interventions including re-orient [NAME] to place, environment, person and time as needed, assist resident with ambulation and/or transfers, bed remote monitoring device is in place (BS) and working properly, resident is high fall risk, red identification arm bang/tag, and keep any assistive devices needed by the resident within reach. During a review of Resident 35's Fall Risk Evaluation dated 7/12/2026, the resident was high risk for fall, indicating that resident was impulsive, lacks understanding of physical and cognitive limitations, with one to two falls in the past 3 months, was ambulatory/incontinent, had visual and hearing impairments, balance problems while standing and walking. requires assistive devices (i.e., cane, wheelchair, walker, furniture) During a concurrent observation and interview on 7/15/2026 at 11:55 a.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated that the facility has a treatment plan and interventions for fall prevention. CNA 2 stated that residents identified as being at high risk for fall are closely monitored. CNA2 stated that it is staff's responsibility to ensure that walkers are positioned within residents' reach at all times. CNA 2 stated that Resident 35 is high risk for fall and that she had already fallen back in May and another just recently. CNA 2 stated facility is providing CNAs with a phone that is connected to the bed, wherein motion is detected when residents are moving in bed, it is also used for repositioning. CNA 2 was questioned regarding a photograph of residents outside the room at the door specifically about the significance of the red strip visible in one resident's photo. CNA 2 stated that it may have been part of the picture and said that there are no other interventions posted anywhere else. During an interview on 7/15/2026 at 1:54 p.m. with Clinical Supervisor (CS), the CS stated that a color-coding system is used to identify the level of risk for fall residents. The CS stated that the facility uses a red strip underneath placed underneath the photo of the residents posted by the door. During an interview on 7/16/2026 at 9:53 a.m. with Licensed Vocational Nurse 2, LVN 2 stated Resident 35 had a recent fall and fall interventions are in place for the resident. LVN 2 stated that interventions such as bed sensor (BS) connected to mobile device for tracking resident's movement while in bed, posted sign indicating high fall risk by the lamp or head of bed are being used. LVN 2 stated that she is uncertain if residents must wear a wristband or of any other interventions. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/16/2026 at 10:48 a.m. with Clinical Supervisor (CS), the CS stated that part of the intervention was to place a red strip on the resident's photo by the door. CS stated that it is important to have the red strip for other staff to be aware and recognize that the residents are at a high risk for fall. CS also stated that the resident had a fall in May 2026. During the second interview on 7/17/2026 at 2:39 p.m. with the CS, the CS indicated that door in the picture was not labeled with red strip and further stated that the policy was not being followed regarding fall interventions. During a review of the facility's Policy and Procedure (P&P) titled, Falls reviewed on 12/04/2025, the P&P indicated Residents are evaluated for their risk for falls using the Fall Risk Evaluation. Residents are evaluated for their fall risk upon admission to the facility, (.), following a fall. Recent falls will be reviewed during the IDT meetings; interventions will be implemented in accordance with the resident's needs. Fall risk identifier: Based upon the score of the Evaluation, residents will be provided with color identification Yellow color identification for low risk &ndash; a score of 13 and below. Red color identification for high risk &ndash; a score of 14 and above. Any resident without a color identification will be considered high fall risk until clarified. Fall Intervention Guidelines: The evaluation of fall risk for each resident will be completed by using the Fall Risk Evaluation. These guidelines for falls prevention can be individualized based on the resident's needs evaluation. -High fall risk (14 points and above represents high risk).		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents who need respiratory care were provided care consistent with professional standards of practice for two of two sampled residents (Resident 8 and 93) reviewed under the Respiratory care area by failing to: 1. Ensure supplemental oxygen (O2) was administered per physician orders, documented when administered, and monitored while in use for Resident 93. 2. Ensure Resident 8's nasal cannula (NC, a small plastic tube, which fits into the nostrils for providing supplemental O2) tubing was identified by CNA 2 when it was on the ground, was not placed by RNA 2 on the resident's bed linens after being removed from the ground and was replaced by LVN 9 after the tubing was on the ground. These failures had the potential to place Resident 93 and Resident 8 at risk for respiratory distress with a delay in necessary care and treatment and respiratory infections from cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) Findings: 1. During a review of Resident 93's History and Physical (H&P), dated 2/11/2026, the H&P indicated the resident was admitted on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), bronchiectasis (a chronic lung disease causing the airways, called bronchi, to become damaged and widened over time), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and chronic use of supplemental O2. During a review of Resident 93's Minimum Data Set (MDS - resident assessment tool) dated 5/19/2026, the MDS indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated the resident required partial/moderate assistance from staff for oral and personal hygiene, toileting, bathing, and mobility. During a review of Resident 93's Physician Orders, the Physician Orders indicated orders for the following: - Oxygen Therapy at bedtime: Routine O2, three (3) liters per minute (LPM - a unit of measurement) via NC, place on O2 during sleep every night for COPD, dated 2/11/2026. - Oxygen Therapy daily as needed (PRN) O2, 3 LPM via NC, use during the day if napping or if O2 saturation (Sa O2 - a unit of measurement) was less (<) 90 percent (%) for COPD, dated 2/11/2026 and discontinued 4/6/2026. - Monitor Sa O2 twice a day, notify medical provider if Sa O2 is below 90%, dated 4/6/2026. During a review of Resident 93's Care Plan (CP) titled, (Resident 93) has alteration in respiratory function related to COPD . dated 2/11/2026, the CP indicated a goal that the resident would maintain oxygenation as demonstrated by decreased work of breathing and would maintain a respiratory pattern and rate within accepted parameters. The CP interventions to achieve these goals included to observe for signs of respiratory distress including shortness of breath and decreased Sa O2 and notify the physician as indicated. During a concurrent observation and interview on 7/13/2026 at 10:21 a.m., with one (1): 1 Sitter (S) 2, observed Resident 93 sitting at bedside while administered O2 at 3 LMP via NC. S2 stated Resident 93 required a 1:1 Sitter and uses continuous O2 via NC 24 hours a day. S2 stated Resident 93 had been administered O2 all morning. During an interview on 7/14/2026 at 12:30 p.m., with Family Member (FM) 1, FM 1 stated he visits Resident 93 often and the resident was administered O2 on and off during the day. FM 1 stated the surveyor would need to speak with the facility staff regarding when the O2 was administered. During a concurrent observation and interview on 7/15/2026 at 8:50 a.m., observed Resident 93 sitting at bedside while administered O2 at 2 LMP via NC. S2 stated Resident 93 had been administered O2 since she arrived at about 7 a.m. During a concurrent interview and record review on 7/15/2026 at 9:18 a.m. with Licensed Vocational Nurse (LVN) 11, LVN 11 reviewed Resident 93's physician orders and medication (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). LVN 11 stated the facility procedure for administering O2 is to check the resident's Sa O2 and administer O2 per the physician's orders. LVN 11 stated Resident 93 was administered supplemental O2 at night and as needed during the day when the residents Sa O2 was < 90%. LVN 11 stated Resident 93 sometimes needed O2 during the day when he was short of breath or complained that he could not breathe. LVN 11 stated Resident 93 was currently being administered O2 via NC. LVN 11 reviewed Resident 93's physician orders and noted the resident had not had an order to administer PRN O2 during the day since 4/6/2026. LVN 11 stated since 4/6/2026, Resident 93's orders indicated to check the resident's Sa O2 and call the physician if it was <90%. LVN 11 stated without a physician's order, the resident should not be administered O2, but he was. LVN 11 stated when oxygen is administered it should be documented in the MAR and monitored. LVN 11 stated he did not know who placed the O2 via NC on the resident or when it was administered because there was no documentation in the resident record because there was no physician's order to administer it. During a follow up interview on 7/15/2026 at 12:58 p.m. with LVN 11, LVN 11 stated it was important to obtain a physician's order prior to administering O2 via NC because the LN cannot do anything without a physician's order. LVN 11 stated the physician determines the treatments for residents. LVN 11 stated it was important to monitor and document a resident's need for and use of O2 via NC because the staff needs to know how the resident is doing and the resident may have a change of condition (COC) when the need for supplemental O2 increases. LVN 11 stated when Resident 11 was administered O2 via NC without a physician's order, without documentation, and was not monitored while administered O2 via NC there was the potential to result in a missed COC and a delay in care for the resident. During an interview on 7/15/2026 at 3:25 p.m. with RN 1, RN 1 stated supplemental O2 is considered a medication. RN 1 stated when a resident has a physician's order for O2 via NC only at night and then requires O2 during the day, the process is to notify the physician and get a physician's order to administer during the day. RN 1 stated when supplemental O2 via NC is administered the process is to document the administration and monitor the use. RN 1 stated she had observed Resident 93 administered O2 via NC during the day on occasion, but she assumed the resident had an order for PRN O2 via NC, but he did not. RN 1 stated when Resident 93 was administered O2 via NC on 7/13/2026, 7/14/2026, and 7/15/2026 during the day without a physician's order, was not documented as administered, and was not monitored while administered, it was considered a medication variance potentially resulting in worsening of COPD or potentially resulting in an unidentified COC with a delay in treatment leading to a serious injury like respiratory failure. RN 1 stated the LNs did not follow the standard of practice to assess the resident for increased need of O2 via NC, notify the physician, obtain an order for administration, document the administration of O2 via NC, and monitor the resident while O2 via NC was administered. During a concurrent interview and record review on 7/17/2026 at 2:05 p.m., with the Clinical Supervisor (CS), the CS reviewed Resident 93's Vital Signs for Sat O2 from 5/2026 to 7/2026 and policy and procedure for oxygen and medication administration. The CS stated the process for when a resident has a new need for oxygen is to assess for the need, then notify provider, check the order before administering the O2 via NC, monitor the use, and document. The CS stated the LN needed to monitor the O2 administration to ensure it was effective and that the resident was not getting worse resulting in a COC. The CS stated the resident could decompensate and become hypoxic (low levels of oxygen in the body tissues) leading to altered mental status (AMS) and falls. The CS stated all of this needs to be documented in the resident's record for the interdisciplinary team (IDT) to evaluate the resident needs and determine the plan of care. The CS reviewed Resident 93's vital signs for Sa O2 and stated (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the resident was documented as using O2 via NC on the following dates and times without a physician order, documentation of need and length of use, or monitoring: On 5/1/2926 at 2:43 p.m., Resident 93's Sa O2 was 95.0% on 3 LPM O2 via NC On 5/5/2026 at 3:38 p.m., Resident 93's Sa O2 was 98.0% on 2 LPM O2 via NC On 5/21/2026 at 8:16 a.m., Resident 93's Sa O2 was 93.0% on 2 LPM O2 via NC On 5/29/2026 at 2:23 p.m., Resident 93's Sa O2 was 90.0% on 3 LPM O2 via NC On 6/14/2026 at 12:20 p.m., Resident 93's Sa O2 was 92.0% on O2 via NC, no LPM indicated On 6/18/2026 at 8:20 a.m., Resident 93's Sa O2 was 93.0% on 2 LPM O2 via NC On 6/18/2026 at 10:37 a.m., Resident 93's Sa O2 was 97.0% on 2 LPM O2 via NC On 6/21/2026 at 8:39 a.m., Resident 93's Sa O2 was 90.0% on 3 LPM O2 via NC On 6/23/2026 at 8:18 a.m., Resident 93's Sa O2 was 90.0% on 4 LPM O2 via NC On 6/24/2026 at 7:57 a.m., Resident 93's Sa O2 was 90.0% on 2 LPM O2 via NC On 6/25/2026 at 7:58 a.m., Resident 93's Sa O2 was 91.0% on 3 LPM O2 via NC On 6/30/2026 at 6:26 p.m., Resident 93's Sa O2 was 96.0% on 2 LPM O2 via NC On 7/2/2026 at 9:02 a.m., Resident 93's Sa O2 was 92.0% on 2 LPM O2 via NC On 7/4/2026 at 4 p.m., Resident 93's Sa O2 was 90.0% on 2 LPM O2 via NC On 7/9/2026 at 6:06 p.m., Resident 93's Sa O2 was 94.0% on 2 LPM O2 via NC On 7/15/2026 at 9 a.m., Resident 93's Sa O2 was 93.0% on 3 LPM O2 via NC The CS stated the facility P&P was not followed for Resident 93's use of supplemental O2 via NC potentially resulting in delay of care and necessary treatment for the resident. During a review of the facility P&P titled, Oxygen Therapy - Oxygen Concentrator, last reviewed 12/4/2025, the P&P indicated, I.POLICY. To safely administer oxygen via mask (simple mask) or nasal cannula to treat and prevent the symptoms of hypoxia. Only an RN or medical provider can initiate or adjust oxygen liter flow or concentration. II. PROCEDURE. 2. Check the medical provider's order . 10. Document in the Electronic Medical Record. During a review of the facility procedure titled, Medication Administration, last reviewed 12/4/2025, the P&P indicated, Medication shall be accurately and safely administered. 2. A physician's order must include: a. Date and time of the order b. Name of the medication and dose c. Dosage form and strength/concentration d. Frequency e. Route f. Reason for PRN administration g. Indication h. Duration, if applicable i. Date, Time and Signature of MD/RN. 2. During a review of Resident 8's H&P, dated 12/26/2025, the H&P indicated the resident was admitted to the facility 11/1/2022 with diagnoses that included Alzheimer's Disease, heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), and hypertension (HTN-high blood pressure). During a review of Resident 8's MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required partial/moderate assistance from staff for eating and toileting and required substantial/maximal assistance from staff for oral and personal hygiene and dressing. During a review of Resident 8's Physician Orders, the Physician Orders indicated orders for the following: - Oxygen Therapy: Routine O2, 2 LPM via NC, continuous - notify the provider if Sa O2 < 90%, dated 7/8/2026. During a review of Resident 8's CP titled, Short Term CP: ineffective breathing pattern related to hypoxia., dated 7/8/2026, the CP indicated a goal that the resident would have no signs and symptoms of respiratory distress and would not develop any complications. The CP interventions to achieve these goals included to check proper placement of oxygen tubing every shift and PRN. During an observation on 7/13/2026 at 12:30 p.m., inside Resident 8's room, observed Resident 8 sitting in bed administered O2 via NC, observed the NC tubing prongs at the resident's nostrils, the NC tubing was connected to the concentrator (device used to provide supplemental O2) placed on the right side of the bed. Observed the connected NC tubing was resting on the ground on the right side of the bed and not placed in the provided clear plastic bag located at the left side of the bed. Observed Certified Nursing Assistant (CNA) 2 standing on the right side of the bed speaking with the resident. Observed CNA 2 exited the room and the NC tubing remained on the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Motion Picture and T.V. Hosp D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 23388 Mulholland Dr. Woodland Hills, CA 91364	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ground. During a concurrent observation and interview on 7/13/2026 at 12:55 p.m., inside Resident 8's room, with Restorative Nurse Assistant (RNA) 2, observed Resident 8 sitting in bed while administered O2 via NC, observed the NC tubing remained on the ground on the right side of the bed. Observed RNA 2 entered the room, confirmed the NC was on the ground, and stated NC tubing should not be on the ground. Observed RNA 2 picked the NC tubing up off the ground and placed it on the Resident's bed. During a concurrent observation and interview on 7/13/2026 at 1:10 p.m. with LVN 9, at HH East Nursing Station, LVN 9 stated NC tubing should not be on the ground. LVN 9 stated all staff are responsible for notifying the LN if a resident's NC is found on the ground. LVN 9 stated she was assigned to Resident 8 and was not informed that the NC was on the ground, but she would go check the resident. LVN 9 reviewed a photo provided by the surveyor of Resident 8's NC tubing on the ground. Observed LVN 9 walked to Resident 8's room and stated the NC tubing was no longer on the ground and exited the room. LVN 9 then stated the NC tubing only needed to be changed when the nasal prong portion of the NC was on the ground. During an interview on 7/13/2026 at 1:15 p.m. with LVN 11, LVN 11 stated NC tubing should not be on the ground. LVN 11 stated when NC tubing is found touching the ground, the NC should be changed and not placed back on the resident's bed for infection control reasons. During an interview on 7/13/2026 at 1:20 p.m. with the CS, the CS stated NC tubing should never be on the ground because there are bags for each resident that hold the tubing to ensure the tubing is kept off the floor. The CS stated if NC tubing is found on the ground, the NC should be removed and changed and not moved from the ground to the clean bed. The CS stated when Resident 8's NC was not identified as being on the ground by the CNA, was moved from the ground to the bed by the RNA and was not changed by the LVN there was the potential to result in respiratory infections in the resident. During a follow- up concurrent interview and record review on 7/17/2026 at 2:05 p.m. with the CS, reviewed the facility P&P regarding oxygen therapy and infection control. The CS stated when Resident 8's NC was on the ground, placed on the bed, then not changed, the facility P&Ps were not followed because the P&P indicates to change the NC PRN and to keep the tubing in the bag to prevent it from becoming contaminated on the ground. During a review of the facility P&P titled, Oxygen Therapy - Oxygen Concentrator, last reviewed 12/4/2025, the P&P indicated, I. POLICY. To safely administer oxygen via mask (simple mask) or nasal cannula to treat and prevent the symptoms of hypoxia. 6. Attach appropriate oxygen accessories to the oxygen outlet: a. Attach oxygen tubing to the connector. c. Attach mask or nasal cannula to oxygen concentrator. 8. Place mask or nasal cannula on resident/patient, comfortably and with appropriate positioning. 9. Hang a set-up bag on the wall . 11. Oxygen tubing is dated and replaced weekly and as needed.		

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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 review, the facility failed to ensure safe provision of pharmaceutical services by: 1. Failing to label Resident 38's cyclosporine eye drop (a medicine used to help people with chronic dry eye disease by reducing swelling in the eye) with an open date during the inspection of one (1) of three (3) medication carts (Medication Cart 1) reviewed during the Medication Storage and Labeling task. 2. Failing to indicate the open date and discard Resident 56's ipratropium-albuterol sulfate (also known as duoneb, a prescription liquid solution or medicine that people breathe in through a nebulizer [a small machine that turns liquid medicine into a mist so a person can breathe it directly into the lungs] to help the airway open up and make it easier to breathe) two (2) weeks after opening as indicated in the medication label. 3. Failing to label Olopatadine HCL (Pataday - eyes drops that help relieve itchy, red, watery eyes caused by allergies, such as pollen and dust) with an open date for one resident (Resident 76) during the inspection of one of five medication carts (Medication Cart 2) investigated during the Medication Storage and Labeling task. 4. Failing to label two floor stock bottles of Milk of Magnesia (a medication used to relieve constipation by drawing water into the intestines, which softens the stool and makes it easier to have a bowel movement) with an open date during the inspection of two of five medication carts (Medication Cart 2 and Medication Cart 3) investigated during the Medication Storage and Labeling task. These failures had the potential to administer expired/outdated medications to residents that can cause adverse reactions (an unwanted, unpleasant, or harmful effect caused by medicine or medical treatment), for medication error and contaminate the medications stored inside the medication cart. 5. Failing to ensure the narcotic (is a strong pain medication that is carefully controlled because it can be habit-forming and has a risk of misused) key was not left unattended in Medication Cart during the inspection of one of three medication carts (Medication Cart 2) investigated during the Medication Storage and Labeling task. This failure had the potential to allow unauthorized access to controlled substances, increasing the risk of medication diversion, theft, or misuse and compromising the security of controlled medication. 6. Failing to ensure medications were securely stored by leaving the medication waste container unlocked while it contained discarded medication including one bubble pack of Pregabalin (Lyrica) (is a medication used to treat nerve pain, certain types of seizures) capsules for one resident (Resident 31) and a Liraglutide (medication that helps lower blood sugar and can help people lose weight) injection. This failure had the potential to allow unauthorized access to medications, resulting in diversion, misuse, accidental ingestion, or harm to residents, staff, or visitors. Findings: 1a. During a review of Resident 38's Face Sheet, the Face Sheet indicated the facility admitted the resident on [DATE]. During a review of Resident 56's History and Physical (H&P) dated [DATE], the H&P indicated that Resident 56 was alert and oriented to person and place. The H&P further indicated the following diagnoses for Resident 56, dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 38 had intact cognition (mental action or process of acquiring knowledge and understanding) and was rarely able to understand others and usually able to make her needs known. The MDS further indicated that Resident 38 required partial or moderate assistance with eating, substantial or maximal assistance with oral hygiene and sitting to lying/lying to sitting, and total assistance from staff with all other activities of daily living (ADLs & activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 38's Physician's Orders dated [DATE], the Physician's Orders indicated an order dated [DATE] for cyclosporine 0.05 percent (% - out of one hundred) instill one (1) drop into both eyes every 12 hours for dry eye syndrome. During a concurrent observation and interview on [DATE] at 2:36 p.m., during an inspection of Medication Cart (Med Cart) 1 in the presence of Licensed Vocational Nurse (LVN) 4, LVN 4 stated that Resident 38's cyclosporine eye drop was open and not labeled with an open date. LVN 4 stated that the practice in the facility is to indicate the date when a medication was opened as the eye drops are only good for 28 days. LVN 4 stated that the licensed nurse who opened Resident 38's cyclosporine eye drop should have labeled the bottle with the open date so the nurses would know that the medicine is not past the use by date or expired. LVN 4 stated that if the eye drop was past the 28 days eye drop would not be effective anymore when used. During a concurrent interview and record review on [DATE] at 3:13 p.m., reviewed Resident 38's physician's orders and a photo of the cyclosporine box and medication label with the Clinical Supervisor (CS). The CS stated that Resident 38's cyclosporine box and label was not labeled with an open date. The CS stated that the licensed nurses are supposed to label the eye drops with the open date as they are only good for 28 days and need to be discarded after that. The CS stated that the licensed nurse who opened Resident 38's cyclosporine should have labeled the eyed drop with the open date so the other licensed nurses would know when to discard the eye drop. The CS stated that Resident 38's cyclosporine would not be effective in treating the dry eyes anymore if past the 28 days. During an interview on [DATE] at 4 p.m. with the Chief Nursing Officer (CNO), the CNO stated that per facility policy, multidose vials of medications such as injectables, eye drops, and insulin should be labeled with an open date unless otherwise specified by the manufacturer. The CNO stated that Resident 38's cyclosporine eye drop should have been labeled with an open date as the medication is only good for 28 days. The CNO stated that the policy was not followed. 2 a. During a review of Resident 56's Face Sheet, the Face Sheet indicated the facility admitted the resident on [DATE]. During a review of Resident 56's H&P, dated [DATE], the H&P indicated that Resident 56 was alert and oriented to person and place. The H&P further indicated the following diagnoses for Resident 56, dementia (a progressive state of decline in mental abilities), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 56's MDS, dated [DATE], the MDS indicated Resident 56 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was rarely able to understand others and usually able to make her needs known. The MDS further indicated that Resident 38 required partial or moderate assistance with eating, substantial or maximal assistance with oral hygiene and sitting to lying/lying to sitting, and total assistance from staff with all other ADLs. During a review of Resident 56's Physician's Orders dated [DATE], the Physician's Orders indicated the following physician's orders: - [DATE] to [DATE]: ipratropium-albuterol sulfate (Duoneb) 0.5 &ndash; three (3) milligrams (mg &ndash; a unit of measurement for medication dosage or amount) per 3, inhale 1 nebulizer (a small, sealed glass or plastic container that holds a single dose of medicine) inhalation every 12 hours for COPD. - [DATE] to [DATE]: Duoneb 0.5 &ndash; 3 mg per 3, inhale 1 nebulizer inhalation every 4 hours while awake for a maximum of 4 doses every 24 hours for COPD with bronchospasms (a condition that occurs when the muscles lining the tubes that carry air to the lungs tighten making it hard to breathe). - [DATE] to [DATE]: Duoneb 0.5 &ndash; 3 mg per 3, inhale 1 nebulizer inhalation every 12 hours for COPD. During a concurrent observation and interview on [DATE] at 2:45 p.m., during an inspection of Medication Cart (Med Cart) 1 in the presence of Licensed Vocational Nurse (LVN) 4, LVN 4 stated that Resident 56's box of ipratropium-albuterol sulfate 0.5 &ndash; three (3) milligram (mg &ndash; a unit of measurement for medication dosage or amount) ampule (a small sealed glass or plastic container that holds a single dose of medicine) with 18 ampules remaining inside an opened foil packaging, did not indicate a date of when it was opened. LVN 4 stated that the medication label indicated to discard the medication 2 weeks after opening. LVN 4 stated that the nurses are supposed to read the medication label and check for the open date and when to discard the medication. LVN 4 stated that if the box of medication was not labeled with an open date and the medication label indicated to discard 2 weeks after opening, the licensed nurses would not be able to know when to discard. LVN 4 stated that if the ipratropium-albuterol was opened past the 2 weeks, the medication would not be effective when administering thru the nebulizer and placed Resident 56 at risk for worsening COPD with bronchospasms. During a concurrent interview and record review on [DATE] at 3:15 p.m., reviewed Resident 56's physician's orders and a photo of the Duoneb medication label with the Clinical Supervisor (CS). The CS stated that Resident 56's Duoneb medication label did not indicate an open date and the medication label indicated to discard the medication after 2 weeks of opening the foil packaging. The CS stated that the licensed nurses are supposed to indicate on the Duoneb box the open date once the foil packaging inside was opened. The CS stated that the licensed nurse who opened Resident 56's Duoneb foil packaging should have labeled the box with the open date so the other licensed nurses would know when to discard the unused nebulizers. The CS stated that Resident 56's (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cyclosporine would not be effective when administering the duoneb and placed Resident 56 at risk for worsening of the COPD. During an interview on [DATE] at 4 p.m. with the Chief Nursing Officer (CNO), the CNO stated that per facility policy, only multidose vials of medications such as injectables, eye drops, and insulin should be labeled with an open date unless otherwise specified by the manufacturer. The CNO stated that if Resident 56's duoneb medication indicated to discard 2 weeks after opening the foil packaging, the medication should have been labeled with the open date so that the licensed nurses would know when to discard the unused duoneb nebulers should have been labeled with an open date as the medication is only good for 28 days. The CNO stated that the policy was not followed. 3a. During a record review of Resident 76's Face Sheet, the Face Sheet indicated the facility admitted the resident on [DATE], with diagnoses including dry eye syndrome of left lacrimal gland (a condition where the eye does not make enough tears, causing the eye to feel dry and irritated); other chronic allergic conjunctivitis (a long-term eye allergy that causes ongoing irritation and inflammation of the lining of the eye). During a review of Resident 76's H&P, dated [DATE], the H&P indicated the resident remained alert, oriented, and cooperative. During a review of Resident 76's MDS, dated [DATE], the MDS indicated the resident had memory problems and some difficulty in new situation. During an observation of Medication Cart (Med Cart) 2 on [DATE] at 1:28 p.m. with Licensed Vocational Nurse (LVN) 8, observed the following: 1. LVN 8 opened the top left drawer of the cart and observed there was no open date on Resident 76's Pataday eye drops and LVN 8 stated the eye drops need an open date because the eye drops are only good for 28 days. LVN 8 stated that with the eye drops not having an open date, staff will not know how long the drops have been opened and can cause Resident 76 eye irritation, redness or might not be effective. 2. LVN 8 open right middle drawer observed a facility stock bottle of Milk of Magnesia with no open date and other bottles of Milk of Magnesia had an open date. LVN 8 stated was not sure if multidose bottles need an open date. LVN 8 stated was going to find out. 3. LVN 8 opened the right upper drawer and observed keys with a black stretchy plastic band. LVN 8 stated that one of the keys was the narcotic key and should not have left it inside the medication cart. LVN 8 stated that the narcotic key is supposed to be always carried by the licensed nurse and by the end of shift passed on to the oncoming nurse. LVN 8 stated that if key is left behind anyone can grab the key and use it to open the narcotic drawer and possibly take medication. During an interview on [DATE], at 2:25 p.m., with Registered Nurse (RN) 1 stated that eye drops are (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	supposed to have an open date because they are only good for 28 days after opening. RN 1 stated that the open date is needed to prevent infection contamination and maintain patency and if it does not have an open date then staff will not know if the eye drops are effective. During an interview on [DATE] at 9:50 a.m., with Chief Nursing Officer (CNO), CNO stated the eye drops need to have an open date because the eye drops are only good for 28 days after opening. The policy titled, Dating of Multidose Vials was reviewed and CNO stated that the policy was not followed. During an interview on [DATE], at 2:25 p.m., with Registered Nurse (RN), RN 1 stated that narcotic keys should not be left inside medication cart the licensed nurse always has to carry the key and give it to next shift nurse. RN 1 stated licensed nurse need to carry key because there are controlled substances (medication that has a risk for misuse, abuse, or addiction, so it is regulated by law) in the lock drawer and whoever gets the key they can open drawer and it becomes a safety risk, compromises the cart count, and there is a risk for diversion of narcotics. During an interview on [DATE] at 9:25 am with Pharmacist (Pharm) 2, Pharm 2 stated floor nurse keeps the narcotic key to the medication cart and is passed to next shift nurse. Pharm 2 stated that the licensed nurse needs to always carry the narcotic key and key should not have been left inside medication cart because anyone who has access to the cart can get the key and can get access to the narcotics. Pharm 2 stated that the policy titled Controlled Drugs, was not followed. During a review of Medication Cart (Med Cart) 3 on [DATE] at 1:45 p.m. with Licensed Vocational Nurse (LVN) 10, open the right middle drawer and observed a facility stock bottle of Milk of Magnesia with no open date. LVN 10 stated that liquid multidose bottles are supposed to have an open date. During an interview on [DATE] at 9:50 am with Chief Nursing Officer (CNO), CNO stated the Milk of Magnesia bottle needs to have an open date because it expires 60 days after open date according to manufacturer. 6a. During a record review of Resident 31's Face Sheet, the Face Sheet indicated the facility admitted the resident on [DATE], with diagnoses including history of right-side shingles with chronic neuropathy (a painful rash on one side of the body cause by a virus and the nerves on the right side of the body continue to cause pain, burning, tingling, or numbness even after the rash has healed). During a review of Resident 31's H&P, dated [DATE], the H&P indicated the resident was alert, oriented, calm, pleasant and cooperative. During a review of Resident 31's MDS, dated [DATE], the MDS indicated the resident can make self understood and had the ability to usually understand others. During a review of Resident 31's Pharmacy Orders, the Pharmacy Order Indicated Pregabalin (Lyrica) 50 mg, Give 50 mg (1 capsule) by mouth twice a day with an order of date [DATE]. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Medication Storage and Labeling task in Med Storage 1 on [DATE] at 1:30 p.m., with Registered Nurse (RN) 2 observed medication waste container not locked and observed inside container a bubble pack of Lyrica capsules for Resident 31 and Liraglutide injection. RN 2 stated that the medication waste container needs to be always locked because anyone can open the lid and get the medication that is inside the container and misuse it. During an interview on [DATE] at 9:25 am with Pharmacist (Pharm) 2, Pharm 2 stated that the medication waste container is supposed to be always locked so no one unauthorized can get any medications out of the container. Pharm 2 stated that the medication waste container is for medication vials, pills, and insulin pens. During a review of the facility's policy and procedure (P&P) titled, Dating of Multidose Vials, last reviewed on 4/2025, the P&P indicated that all multiple dose vials such as multi-dose injectable vials, eye drops, and insulin containing a preservative are given a consistent expiration date. The P&P further indicated: - Beyond Use Dating (BUD): - Commercially Prepared Unaltered Medications: Unless otherwise specified by the manufacturer, the BUD for any commercially prepared medication that has not been compounded, admixed, or otherwise altered, shall be the expiration date listed by the manufacturer. If the manufacturer had established a shorter BUD once the medication has been accessed, then that shall be considered the BUD. - BUD for Multi-dose Vials: Unless otherwise specified by the manufacturer, the BUD for multi-dose medication vials with antimicrobial preservatives which have been opened or entered, is 28 days. If the manufacturer has established a shorter BUD once the medication has been accessed, then that shall be considered the start of the 28-day BUD. The BUD must be noted on the medication vial. - Procedure: 1. Date multi-dose vial after opening. 2. The person opening the vial should initial the vial. 3. 28 days from the date of opening, the vial will be discarded and deemed expired. During a review of the facility's Policy & Procedure (P&P) titled, Controlled Drugs reviewed on 6/2024, the P&P indicated storage areas must be kept locked at all times. Only persons licensed to administer controlled drugs can control the keys to the storage areas. The keys cannot be left in any area or special place for access but must be carried by someone licensed to administer controlled drugs.		

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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 ensure safe and sanitary food storage and food preparation practices in the kitchen by: 1. Failing to ensure a bag of shredded lettuce was not sealed and not labeled with an open date. 2. Failing to ensure the test strip used to check the sanitizing solution was not expired. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 97 out of 97 medically compromised residents who received food from the kitchen. Findings: During an observation while performing the initial kitchen tour on 7/13/2026 at 8:15 a.m. inside the walk-in produce refrigerator with the Director of Hospitality (DH), observed an open bag of lettuce and not labeled with an open date. The DH stated that the kitchen staff are supposed to seal and label items in the kitchen when opened. The DH stated that the facility has a new labeling machine that was implemented in the past year and that the kitchen staff were in-serviced on how to use them. The DH stated that the kitchen staff who opened the bag was supposed to seal the bag after when opened and labeled with the open date. The DH stated that if the bag of shredded lettuce was left open it could get contaminated and cause stomach issues with the residents. The DH stated that if the bag did not indicate a label with open date, the staff would not be able to know if the shredded lettuce was past the best by date. During an interview while conducting a follow up visit in the kitchen on 7/16/2026 at 11:35 a.m. with the Registered Dietitian (RD) in the nourishments or snacks preparation area. The RD stated that each kitchen staff have their own red bucket for the sanitizing solution to clean the preparation area surfaces when soiled and before and after each preparation. During a concurrent observation and interview on 7/16/2026 at 11:37 a.m. in the nourishments and snacks preparation area with Tray Line Worker (TLW) 1, TLW 1 demonstrated how to test the sanitizing solution by using the Quat Test Paper (QTP) 1 strip. When TLW 1 was asked to check the holder or case for the test QTP 1, the test strip case indicated an expiration date of 4/1/2026. TLW 1 stated that the test strip was expired and unable to tell the last time the test strip was used. TLW 1 stated that if the QTP 1 strip was expired, the result of the test would not be accurate and the sanitizing solution would not be effective in cleaning the surfaces and can lead to cross-contamination (transfer of harmful bacteria, allergens, or chemicals from one food, surface, piece of equipment, or person to another which can cause foodborne illnesses [an illness caused by consuming contaminated foods or beverages]). During a concurrent observation and interview on 7/16/2026 at 11:45 a.m., with the DH, The DH stated that the QTP 1 strip that TLW 1 attempted to use prior to testing the sanitizing solution had an expiration date of 4/1/2026. The DH stated that the tray line workers might just be replacing the roll of test strip when finished instead of using a new holder or container for the QTP 1 strip each time the test strip is changed. The DH stated that TLW 1 should have checked the expiration date on the test strip case prior to checking the quat for the sanitizing solution as the reading or result would not be accurate and not be effective in cleaning the surfaces and can cause cross-contamination. During an interview on 7/17/2026 at 1:35 p.m. with the Clinical Supervisor (CS), the CS stated that bag of shredded lettuce should have been sealed and labeled with an open date. The CS stated that if the bag of shredded lettuce was left open, the contents would be exposed to possible contaminants and get contaminated and cause stomach issues to the residents. The CS stated that the kitchen staff should have labeled the bag of shredded lettuce with an open date to ensure the staff would know when to discard. During a review of the facility's (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy and procedure (P&P) titled, Sanitizing Food Contact Surfaces, last reviewed on 2/19/2026, the P&P indicated: - Each work area should be equipped with sanitizing solution. - Sanitize food contact surfaces after they have been thoroughly washed and rinsed. - Follow the instructions on the test strip package for the temperature of the solution when tested and the process that must be followed. - Use one of the following products: - Sanitizing Solution (SS) 1 at a concentration of 200-400 parts per million (ppm - measures the concentration of the active chemical in the mixture). - Other approved chemical sanitizer that is applied in accordance with manufacturer's usage directions. - Sanitizer test strips are readily available whenever sanitizer is dispensed - Red Buckets: - Use a clean bucket each time sanitizer solution is replaced - Change sanitizer solution whenever it becomes heavily soiled and/or falls out of the effective usage range (200-400 ppm). Best practice: change it out to a minimum of every two (2) hours. - Adhere to the concentration listed above. During a review of the facility's P&P titled, Food and Supply Storage, last reviewed on 2/19/20206, the P&P indicated all food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. The P&P further indicated: - Most, but not all, products contain an expiration date. The words sell by, best-by, enjoy-by, or use by should precede the date. The sell by date is the last date that food can be sold or consumed; do not sell products in retail areas or place on patient trays/resident plates past the date on the product. Foods past the use by, sell by, best by, or enjoy by date should be discarded. - Cover, label and date unused portions and open packages. Use the Medvantage/Freshdate labeling system or complete all sections on an orange label. Products are goof through the close of business on the date noted on the label. - Date and rotate items; first in, first out. Discard food past the use-by or expiration date.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on observation, interview, and record review, the facility failed to obtain informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for one of five sampled residents (Resident 5) for duloxetine (a psychotropic medication [any medication capable of affecting the mind, emotions, and behavior] classified as an anti-depressant [treats persistent feelings of sadness and loss of interest that can interfere with daily living]). This failure had the potential to result in the use of unnecessary psychotropic drugs resulting in adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) and a violation of Resident 5's right to make medical decisions regarding the use of psychotropic medications. Findings: During a review of Resident 5's Face Sheet (admission Record), the Face Sheet indicated the facility originally admitted the resident on 12/15/2022. During a review of Resident 5's History and Physical (H&P), dated 8/31/2025, the H&P indicated the resident's most recent admission was 9/6/2023 with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic pain, and depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 5's Minimum Data Set (MDS - resident assessment tool), dated 5/5/2026, the MDS indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS further indicated the resident was dependent on staff for eating, oral and personal hygiene, toileting, bathing, mobility, and dressing. The MDS indicated Resident 5 was taking high risk antidepressant medication. During a review of Resident 5's Physician Orders, the Physician Orders indicated an order for the Duloxetine HCL, 30 milligrams (mg, a unit of measurement) one (1) capsule by mouth daily per physician recommendations for chronic musculoskeletal pain, dated 4/25/2026. During a review of Resident 5's Care Plan (CP) regarding the resident experienced an alteration in comfort related to complaints of back pain, dated 9/6/2023 with a target date of 8/31/2026, the CP indicated a goal that the resident would not exhibit untoward behavior such as agitation, irritability, and restlessness while awake with interventions that included to administer pain medication as ordered and monitor for psychotropic side effects of duloxetine including appetite changes, nausea, vomiting, diarrhea, falls, dry mouth, headache, anxiety, hypertension (HTN - high blood pressure), and insomnia. During an interview on 7/13/2026 at 3:41 p.m., observed Resident 5, in bed awake. Resident 5 stated he gets back pain. During a concurrent interview and record review on 7/16/2026 at 10:40 a.m., with Registered Nurse (RN) 1, reviewed Resident 5's physician orders and informed consent forms for psychotropic medication. RN 1 stated psychotropic medications are high risk medications that manage resident behaviors and affect the brain. RN 1 stated the physician obtains informed consent prior to the administration of psychotropics to ensure the residents and family are aware of the risks of taking the medication. RN 1 stated antidepressants are psychotropic medications. RN 1 then stated Resident 5 was prescribed and administered duloxetine, an antidepressant, for off label use for pain management and there was no documented evidence that informed consent was received for Resident 5's use of duloxetine. RN 1 stated she (RN 1) was not sure if informed consent was needed when duloxetine was administered for pain management. During a concurrent interview and record review on 7/17/2026 at 8 a.m. with the Chief Nursing Officer (CNO), reviewed the facility P&Ps regarding psychotropic medication and informed consent. The CNO stated duloxetine was a psychotropic medication and required informed consent be completed by the primary care provider prior to administration. The CNO stated it was an oversight that informed consent was not obtained for (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5's use of duloxetine because the medication was prescribed for pain management, but it should have been. The CNO stated the facility P&P was not followed when Resident 5 was administered duloxetine for pain management without being aware of the risks of the medication potentially resulting in possible adverse effects. The CNO stated when a psychotropic medication is used without informed consent it may potentially be considered the unnecessary use of psychotropics leading to a chemical restraint. During a review of the facility policy and procedure (P&P) titled, Psychotherapeutic Medication-Monitoring/Informed Consent, approved on 12/4/2025, the P&P indicated Psychotherapeutic drug is a drug to control behavior or to treat thought disorder processes, The use of psychotherapeutic medications in the Long Term Care setting shall be instituted only when resident's symptoms and behaviors have not responded to non-pharmaceutical approaches and with the informed consent of the resident and/or representative. Psychotherapeutic medication will never be administered for the use of discipline or nursing convenience. II. PROCEDURE. A. When psychotherapeutic drugs are used: 1. The lowest effective dose will be prescribed. 2. Residents will be monitored to determine the drug's effectiveness for the treatment of the stated condition and any adverse reaction 3. Medical Provider orders are to include the following elements: . e. Documentation of obtaining informed consent. During a review of the facility P&P titled, Obtaining Informed Consent, approved on 6/2017, the P&P indicated, This policy will establish guidelines and principles in obtaining an informed consent. each resident/patient has a right to have his or her cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected. informed consent be obtained by the physician prior to any . procedures considered high risk and any procedure for which informed consent is required by law. All conversations with patient, family or surrogate decision makers shall be documented in the medical record. If the individual is unable to make healthcare decisions (in the opinion of a medical doctor and/or psychiatrist), the appropriate surrogate may act as an agent on behalf of the individual. to be informed, the patient/resident must receive in understandable terms all information that would affect a reasonable decision to consent or refuse a treatment or procedure. During a review of the facility P&P titled, Patient Rights and Responsibilities, last reviewed on 9/2019, the P&P indicated Consistent with our Mission and Values, . supports the assurance of patient rights . These rights include the patient's right to: . to be free from psychotherapeutic drugs used as a chemical restraint as defined in Section 72018, except in an emergency which threatens to bring immediate injury to the patient or others. If a chemical restraint is administered during an emergency, such medication shall be only that which is required to treat the emergency condition and shall be provided in ways that are least restrictive of the personal liberty of the patient and used only for a specified and limited period of time.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for residents to call a nursing personnel to assist them when needed) within reach of the resident for two of two sampled residents (Residents 67 and 76). This failure had the potential to place Residents 67 and 76 at risk for delayed assistance, potentially affecting safety and timely care. Findings: 1. During a record review of Resident 67's Face Sheet (admission Record), the Face Sheet indicated the facility originally admitted the resident on 3/6/2024 and readmitted on [DATE], with diagnoses Alzheimer's disease, unspecified (a disease characterized by a progressive decline in mental abilities); Type 2 diabetes mellitus with other circulatory complications (a disorder characterized by difficulty in blood sugar control and poor wound healing that has caused problems blood circulation); unspecified glaucoma (an eye disease that can slowly damage vision because of increased pressure or damage to the optic nerve (the nerve that sends message to the brain of you can see)). During a review of Resident 67's Minimum Data Set (MDS- a resident assessment tool), dated 5/9/2026, the MDS indicated the resident can make self understood and can understand others and had intact cognitive function (normal thinking). The MDS indicated that Resident 67's needed dependent to maximal assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 67's Fall Risk Evaluation (FRE), dated 5/1/2026, the FRE indicated the resident was a low risk for falls. During a concurrent observation and interview on 7/13/2026, at 12:11 p.m., with Restorative Nurse Assistant (RNA) 1, inside Resident 67's room, observed the call light on top of the nightstand. RNA 1 observed call light on the nightstand and RNA 1 stated call light is not within reach of Resident 67. RNA 1 stated Resident 67 can potentially fall trying to reach for the call light. During a concurrent interview and record review on 7/16/2026, at 12:16 p.m. with Clinical Supervisor (CS), Resident 67's FRE was reviewed. CS stated Resident 67 was at risk for falls. CS stated that call light should always be within reach of Resident 67 so the resident can call for assistance. CS stated that if call light is not within reach, then Resident 67 can potentially fall trying to reach for call light. CS stated the facility's policy titled, Call Light, was not followed. 2. During a record review of Resident 76's Face Sheet, the Face Sheet indicated the facility admitted the resident on 6/30/2021, with diagnoses including hemiplegia following cerebral infarction affecting left nondominant side (a stroke (blocked blood flow in the brain) caused damage in the brain, leading to either weakness or complete loss of movement on the left side of the body); essential (primary) hypertension (high blood pressure with no known specific cause); type 2 diabetes mellitus with other circulatory complications (a disorder characterized by difficulty in blood sugar control and poor wound healing that has caused problems blood circulation). During a review of Resident 76's History and Physical (H&P), dated 8/21/2025, the H&P indicated the resident remains alert, oriented, and cooperative. During a review of Resident 76's Minimum Data Set (MDS- a resident assessment tool), dated 6/6/2026, the MDS indicated the resident had memory problems and some difficulty in new situation. The MDS indicated that Resident 76 needed dependent to moderate assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 76's FRE, dated 5/12/2026, the FRE indicated the resident was a high risk for falls. During a record review of Resident 76's Care Plan (CP) Report, the focus indicated Resident 76 was at risk for falls related to chronic stroke with left side hemiplegia as evidence by psychotropic (drugs that help treat mental health) or sedation medications, impaired vision (difficulty (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seeing), age greater than 70, impaired mobility. The CP Report indicated the goal is to eliminate or reduce the frequency of falls with an intervention of keep call light within reach. During a concurrent observation and interview on 7/13/2026, at 1:26 p.m., with Licensed Vocational Nurse (LVN) 8 in Resident 76's room, observed resident lying in bed, resident had a sling on left arm and call light was hanging down to the floor from the left upper siderail. Resident 76 stated that the call light should be within reach of the resident because resident can potentially fall trying to reach for the call light. LVN 8 stated the call light is hanging from left bed side rail and the resident would not be able to reach it to call for assistance. LVN 8 stated the resident would not be able to contact the staff and it could be an emergency. LVN 8 stated resident can potentially fall trying to reach for the call light. During a concurrent interview and record review on 7/16/2026, at 11:51 a.m. with Clinical Supervisor (CS), Resident 76's CP and FRE were reviewed. CS stated Resident 76 was a high risk for falls. CS stated call light should have been on the right side of Resident 76 so that resident would be able to call with arm that did not have a sling. CS stated the call light was not within reach of Resident 76 and resident could have fallen trying to reach for things or the call light. CS stated Resident 76's Care Plan and the facility's policy titled, Call Light was not followed. During a review of the facility's Policy and Procedure (P&P) titled, Call Light, last reviewed on 10/2025, the P&P indicated to alert nursing staff that resident has a request or need and to ensure resident has access to call light at all times. Procedure: 8. Ensure the call light is within reach of the resident. If the resident is ambulatory or mobile in a wheelchair, ensure that there is easy access to the call light.		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a safe and comfortable homelike environment for one of one sampled resident (Resident 96) by not ensuring the floor mat was maintained in good condition or replaced when damaged. This failure had the potential for the damaged floor mat to create a trip hazard, increasing the risk for falls and possible injury for Resident 96. Findings: During a record review of Resident 96's Face Sheet (admission Record), the Face Sheet indicated the facility admitted the resident on 6/25/2015, with diagnoses including Alzheimer's disease, with early onset (a disease characterized by a progressive decline in mental abilities at a younger age than usual age); essential (primary) hypertension (high blood pressure with no known specific cause); depression, unspecified (a condition that causes sadness, loss of interest in activities, low energy, and changes in sleep, appetite, or concentration, can affect a person's feelings, thoughts, and daily activities). During a review of Resident 96's History and Physical (H&P), dated 2/25/2026, the H&P indicated the resident was alert and with continued slow/progressive cognitive and physical decline. During a review of Resident 96's Minimum Data Set (MDS- a resident assessment tool), dated 6/5/2026, the MDS indicated the resident rarely/never made self understood and rarely/never understood others and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated that Resident 96 needed dependent assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 96's Nursing Orders, dated 4/16/2025, the Nursing Orders indicated an order for floor mat every shift (QSHIFT), Request Type: Stat Indication: Routine, Comments: Place floor mat on both sides of the bed when resident is in bed, mat may be removed and stored when resident is out of bed. Indication: Provide comfort and reduce impact from fall. During a record review of Resident 96's Fall Risk Evaluation (FRE), dated 6/5/2026, the FRE indicated the resident was a high risk for falls. During an observation on 7/13/2026, at 10 a.m., inside of Resident 96's room observed bilateral mats, one on each side of the resident's bed. The floor mat on the left side had some tears and the corner of the mat was torn, open, lifting, exposing the inner cushion. During a concurrent observation and interview on 7/17/2026, at 9:00 a.m., with Restorative Nurse Assistant (RNA) 3, inside of Resident 96's room observed the floor mat that had tears on the corner and on top of the floor mat. RNA 3 stated the floor mat should not have tears, the floor mat is not in good condition. RNA 3 stated the floor mat should have been replaced, the staff need to report it to central supply personnel so they can replace it. RNA 3 stated that people can trip on the tears of the floor mat. RNA 3 stated that the floor mat having tears does not provide a homelike environment for Resident 96. During an interview for Resident 96 on 7/17/2026, at 9:42 a.m., with Registered Nurse (RN) 1, RN 1 stated the floor mat was damaged and was not promoting homelike environment, can negatively impact Resident 96 on how the resident feels, and can potentially injure staff. During an interview for Resident 96 on 7/17/2026, at 9:50 a.m., with Chief Nursing Officer (CNO), the CNO stated the floor mat should not have been in that condition because it is damaged and it is not on their standards. CNO stated the floor mat will be replaced immediately. During a review of the facility's Policy & Procedure (P&P) titled, Patient Rights and Responsibilities, reviewed on 9/2019, the P&P indicated written policies regarding the rights of patients shall be established and shall be made available to the patient, to any guardian, next of kin, sponsoring agency or representative payee, and the public. Those policies and procedures shall ensure that each patient admitted to the facility has (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the following rights and is notified of the following facility obligations, in addition to those specified by regulation: (e) The facility shall be clean sanitary and in good repair at all times.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 79) was free from the use of chemical restraints (any drug that is used for discipline or staff convenience and not required to treat medical symptoms) by failing to ensure clonazepam (medication used to treat anxiety disorder [a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear])) was prescribed, administered, and monitored for specific, measurable behavioral manifestations. This failure had the potential to result in the administration of unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) and placed residents at increased risk for adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication therapy, such as sedation, drowsiness, dry mouth, blurred vision, muscle tremor, agitation, and possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 79's History and Physical (H&P), dated 12/11/2025, the H&P indicated the resident was admitted on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and hypertension (HTN - high blood pressure). During a review of Resident 79's Minimum Data Set (MDS - resident assessment tool) dated 6/12/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required supervision or touching assistance for staff for eating, oral and personal hygiene, toileting, bathing, mobility and dressing. The MDS further indicated that the resident was taking high risk medications that included an antianxiety medication. During a review of Resident 79's Physician Orders, the Physician Orders indicated orders for the following: - clonazepam, one (1) milligrams (mg - a unit of measurement), give 1 tablet by mouth daily at 6 p.m. Indication: anxiety manifested by (m/b) agitation, dated 2/2/2026. - clonazepam 0.25 mg, give 0.25 mg (one tablet) by mouth every 24 hours as needed. Indication: anxiety m/b agitation, dated 7/1/2026. During a review of Resident 79's Care Plan (CP) regarding the resident's psychological condition and receives psychotropic medications, dated 12/11/2025 with a target date of 9/30/2026, the CP indicated a goal that the resident would have reduced incidents of mood or behavior changes and would be free of falls/injury while receiving the medication with interventions that included to monitor the frequency of exhibited mood / behaviors and to evaluate for effectiveness and side effects of medications for possible decrease / elimination of psychotropic drugs. During an interview on 7/16/2026 at 11:40 a.m., with Pharmacist (Pharm) 1 and Pharm 2, Pharm 2 stated psychotropic medications are considered high risk medications. Pharm 2 stated the goal of psychotropic medication administration is to help the residents become as comfortable as possible with the lowest effective dose of the medication. Pharm 1 stated the lowest effective dose is used to avoid over sedation potentially resulting in adverse effects like dizziness and falls. Pharm 1 stated this goal is achieved by analyzing and making recommendations based on the tallied behavior episodes that are documented and collected by the licensed nurses (LNs). During a concurrent interview and record review on 7/16/2026 at 12:07 p.m. with Licensed Vocational Nurse (LVN) 9, reviewed Resident 79's physician orders and Behavioral Monitoring form dated 7/2026. LVN 9 stated psychotropic behavioral episode monitoring is completed every shift and then tallied monthly by the LN. LVN 9 stated Resident 79 has orders for clonazepam (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Motion Picture and T.V. Hosp D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 23388 Mulholland Dr. Woodland Hills, CA 91364	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily and PRN for agitation. LVN 9 stated Resident 79 demonstrates agitation with demanding behaviors, and he verbalizes a desire to elope (leave the facility). LVN 9 stated the resident used to be monitored for verbalizing desire to elope and demanding behavior, but the monitoring changed on 7/12/2026. LVN 9 stated from 7/12/2026 until now, Resident 79 has only been monitored for agitation and not the behavioral manifestation of verbalizing a desire to elope and demanding behavior. During a concurrent interview and record review on 7/17/2026 at 9:30 a.m. with Registered Nurse (RN) 1, reviewed Resident 79's physician orders and Behavior Monitoring form dated 7/2026. RN 1 stated the facility process is psychotropic medications are ordered, administered, and monitored for resident specific behaviors. RN 1 stated it was important to indicate specific behavioral manifestations, so the LN knows when to administer PRN medication and so the LNs can effectively monitor the behavioral episodes with the goal to decrease the use of high-risk medication. RN 1 stated Resident 79's current orders and Behavioral Monitoring form indicated to monitor for agitation. RN 1 stated agitation is a broad term and agitation looks different in different residents. RN 1 stated agitation can manifest in some residents as pacing back and forth and others as yelling or harassing others. RN 1 stated when Resident 79 gets agitated he paces and verbalizes wanting to leave. RN 1 stated when clonazepam was ordered to be administered and monitored for agitation, the PRN order did not indicate the resident's specific behaviors and the monitoring was not for specific behaviors potentially resulting in the resident not receiving the appropriate treatment leading to the administration of unnecessary psychotropic medication. RN 1 stated it was important to not administer unnecessary psychotropic medication because there was a high risk for side effects leading to resident confusion and injuries. During a concurrent interview and record review on 7/17/2026 at 2:05 p.m. with the Clinical Supervisor (CS), reviewed the facility policy and procedures (P&P) regarding psychotropic medications. The CS stated psychotropic medications have the potential for side effects like psychomotor issues (unintentional and purposeless motions and restlessness) and drowsiness resulting in falls. The CS stated psychotropic medications should be administered and monitored for the focus behaviors a resident exhibits to ensure the resident is treated appropriately and unnecessary psychotropic medication is not administered. The CS stated Resident 79's clonazepam was ordered and monitored for agitation. The CS stated agitation was not specific enough to ensure that the LNs were administering PRN clonazepam for the appropriate behaviors and to ensure clonazepam was monitored for the same behaviors with a goal of decreasing the medication. The CS stated the facility P&P was not followed for Resident 79's PRN administration and monitoring for clonazepam. During a review of the facility P&P titled, Patient Rights and Responsibilities, approved on 9/2019, the P&P indicated Consistent with our Mission and Values (facility name) supports the assurance of patient rights . These rights include the patient's right to: . to be free from psychotherapeutic drugs used as a chemical restraint . During a review of the facility P&P titled, Psychotherapeutic Medication-Monitoring/Informed Consent, approved 12/4/2025, the P&P indicated Psychotherapeutic drug is a drug to control behavior or to treat thought disorder processes, The use of psychotherapeutic medications in the Long Term Care setting shall be instituted only when resident's symptoms and behaviors have not responded to non-pharmaceutical approaches and with the informed consent of the resident and/or representative. Psychotherapeutic medication will never be administered for the use of discipline or nursing convenience.II. PROCEDURE. A. When psychotherapeutic drugs are used: 1. The lowest effective dose will be prescribed. 2. Residents will be monitored to determine the drug's effectiveness for the treatment of the stated condition and any adverse reaction 3. Medical Provider orders are to include the following elements:. e. Indication Behaviorally specific manifestations i.e. psychoses manifested by disturbing delusions II. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PROCEDURE, BEHAVIOR MONITORING FOR PSYCHOTHERAPEUTIC MEDICATIONS. 2. Behaviors are documented by nursing on the electronic health record (EHR). Licensed vocational nurse (LVN) summarizes total monthly behavior count, it is then reviewed and signed by medical provider . 3. Behaviors are documented every shift by the LVN. 4. Behaviors are tallied monthly. 5. All medications will be reviewed quarterly in Resident Care Plan meeting and as needed.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to assess the risk of entrapment (an event in which a resident is caught, trapped, or entangled in spaces in or about the bed rail, mattress, or hospital bed frame) from bed rails/side rails (safety devices, typically metal or plastic bars, that attach to the sides of a bed to help prevent falls or provide support for residents) for one (1) of two (2) sampled residents (Resident 84) reviewed for physical restraints (are any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to the body by the use of any method, attached or adjacent to a person's body that the person cannot control or remove easily) by failing to complete the bed rail risk assessment prior to use of bilateral bed rails. This failure placed Resident 84 at risk for potential accidents such as body parts being caught between the rails and falls that may occur if the resident attempts to climb over, around, between, or through the rails. Findings: During a review of Resident 84's Face Sheet, the Face Sheet indicated the facility admitted the resident on 12/30/2025. During a review of Resident 84's History and Physical (H&P), dated 12/30/2025, the H&P indicated Resident 84 had the capacity to understand and make decisions. The H&P further indicated that Resident 84 had bilateral legs (both legs) lymphedema (a long-lasting swelling caused by a block in the body's drainage system), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 84's Minimum Data Set (MDS, a resident assessment tool), dated 6/30/2026, the MDS indicated Resident 84 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make her needs known. The MDS further indicated that Resident 84 required supervision or touching assistance with eating, partial or moderate assistance with oral hygiene, and total assistance from staff with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 84's Physician's Orders, dated 6/26/2026, the Physician's Orders indicated a physician's order dated 3/4/2026 for bilateral bed rails. During a review of Resident 84's consent for the use of bed rails, dated 3/4/2026, the consent indicated the reason for use as a mobility enabler (a device, support, or intervention used to assist a resident or patient in moving, repositioning, or transferring, especially in bed or during ADLs) and signed by the resident representative. During a review of Resident 84's Bed Safety Assessment form, dated 3/3/2026, the Bed Safety Assessment form indicated a recommendation for use of left upper and right bed rails as a non-restraint. During a review of Resident 84's Bed Rail Risk Assessment, there was no documented evidence that the Bed Rail Risk Assessment was completed prior to installation of the bed rails. During a review of the Resident 84's interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) care conference notes dated 3/3/2026, the IDT notes indicated a recommendation for the use of both upper bed rails for positioning assistance. During a review of Resident 84's Care Plan (CP) titled, At risk for injury and physical deconditioning, entrapment, skin tears, discoloration, and emotional distress initiated on 3/4/2026, the CP indicated IDT discussion on use of bed rails, identify the resident's specific risks associated with the use of bed rails, and assess the resident for risk of entrapment from bed rails prior to installation as a few of the interventions for Resident 84 to remain free of injuries and will not show any sign or symptoms of emotional distress. During a concurrent observation and interview on (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	7/13/2026 at 11:30 a.m., inside Resident 84's room, Resident 84 stated that the bed rails on both sides of the bed helps her when turning and repositioning, especially during ADL care. During a concurrent interview and record review on 7/17/2026 at 1:45 p.m. with Registered Nurse (RN) 2, reviewed Resident 84's physician's order, care plan, bed safety assessment, bed rail risk assessment, IDT notes, and the facility's untitled policy and procedure (P&P) on comprehensive clinical and behavioral assessments and P&P titled, Bed Safety. RN 2 stated that Resident 84 had a physician's order for the use of bilateral bed rails as enabler and a non-restraint, a bed safety assessment and IDT were completed on 3/3/2026 with a recommendation for the use of both upper bed rails for bed mobility and positioning assistance. RN 2 stated there was no Bed Rail Risk Assessment completed for Resident 84 prior to use of the bilateral bed rails. RN 2 stated that the untitled P&P about comprehensive assessments indicated that a bed safety assessment is completed upon admission, annually, and with change of condition and that the bed rail risk assessment is completed before initiating an order for bed rails then annually and with applicable change of condition. RN 2 stated that the P&P titled, Bed Safety, indicated that the resident should be assessed for risk of entrapment from bed rails or bed positioning prior to use. RN 2 stated that a bed safety assessment should be completed upon admission, annually, and with change in condition and the bed rail risk assessment is completed prior to initiation of the order to ensure the resident's safety prior to use of the bed rails. RN 2 stated the P&Ps were not followed which placed Resident 84 at risk for discomfort, entrapment, and other risks associated with the bed rail use. During an interview on 7/17/2026 at 2 p.m. with the Chief Nursing Officer (CNO), the CNO stated that the facility's untitled P&P on frequency of comprehensive clinical and behavioral assessments indicated that both the bed safety assessment and bed rails risk assessment are completed prior to initiation of the use of bed rails. The CNO stated that the bed safety assessment is to ensure that the resident is safe to use bed rails to determine their bed mobility and what type of bed rails to use. The CNO stated that after determination by the IDT the type of bed rails use for a resident, a bed rail risk assessment needs to be completed prior to use to assess the resident safety and risk for entrapment. The CNO stated that the facility missed the completion of Resident 84's bed rail risk assessment prior to use. The CNO stated that the facility's P&P was not followed and that Resident 84's bed rail risk assessment should have been completed prior to use to ensure that Resident 84 was safe and there was not risk of entrapment. During a review of the facility's P&P titled, Bed Safety, last revised on 9/2025 and approved by the governing body (a group of individuals or officials that holds ultimate authority and responsibility for overseeing the administration of an organization) on 12/4/2025, the P&P indicated that it is the policy of the facility to identify and reduce safety risks and hazards associated with bed use to achieve sustainable quality outcomes including individual bed rail evaluations to provide a safe, clean, comfortable, and homelike environment. The P&P further indicated: - Bed Rail/Bed Positioning: - The facility's priority is to ensure safe and appropriate bed rail use and to prevent entrapment and other safety hazards associated with bed rail use of bed positioning. - Bed rails may be utilized, and care planned with informed consent of the resident/resident representative and medical provider order to meet the individualized need. - Upon admission, annually and on a necessary basis, residents will be screened to include the level of independence with bed mobility, assess the need for special equipment or accessories such as bed rails, assess the resident to identify appropriate alternative prior to installing bed rails, and assess the resident for risk of entrapment from bed rails or bed positioning prior to use. During a review of the facility's untitled P&P on comprehensive clinical and behavioral assessments, with an effective date of 7/2026, the P&P indicated that the that the licensed nurses shall perform timely comprehensive, and ongoing clinical and behavioral assessments (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for all residents admitted to or receiving services within the skilled nursing facility. The P&P further indicated: - Bed Safety Assessment is completed upon admission, annually, and with applicable change in condition. - Bed Rail Risk Assessment is completed before initiating the order for bed rails then annually and with applicable change in condition.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to act upon the pharmacist's recommendation for one of five sampled residents (Resident 22) reviewed for Unnecessary Medications, Psychotropic (medications capable of affecting the mind, emotions, and behavior) Medications, and Medication Regimen Review (MRR-a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) care area by failing to follow-up with Resident 22's physician or medical provider regarding the consultant pharmacist's MRR recommendation. This failure placed Resident 22 at risk for receiving inappropriate medication, which could lower their well-being or increase the likelihood of adverse drug effects. Findings: During a review of Resident 22's Face Sheet, the Face Sheet indicated the facility admitted the resident on 4/16/2025. During a review of Resident 22's History and Physical (H&P), dated 4/28/2026, the H&P indicated Resident 22 was alert but disoriented to time and situation. The H&P further indicated that Resident 22 had diagnoses including dementia (a progressive state of decline in mental abilities), chronic pain on the neck and back, and polyneuropathy (a condition that involves damage to many nerves outside the brain and spinal cord causing numbness, tingling, and weakness in the hands and feet). During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 7/3/2026, the MDS indicated that Resident 22 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) but had the ability to understand others make her needs known. The MDS further indicated that Resident 22 required supervision or touching assistance with eating, total assistance with bathing self, partial or moderate assistance with oral hygiene, bed mobility, and transfers, and substantial/maximal assistance with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 22's Physician's Orders dated 6/26/2026, the Physician's Orders indicated an order for: - 7/23/2025: loperamide hydrochloride (also known as Imodium, a medication used to control and relieve symptoms of acute [sudden or short term] and chronic [long-lasting or constantly recurring] diarrhea) two (2) milligrams (mg - a unit of measurement) by mouth 2 times a day as needed if more than 2 loose stools for chronic diarrhea During a review of Resident 22's electronic medication administration records (eMAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 5/2026, 6/2026, and 7/2026, the eMAR did not indicate that Resident 22 received loperamide hydrochloride. During a review of Resident 22's Pharmacy Monthly Chart Review form dated 6/24/2026, the Pharmacy Monthly Chart Review form indicated a recommendation to consider discontinuing loperamide due to not being used. During a review of Resident 22's medical provider's notes dated 7/1/2026, 7/2/2026, 7/6/2026, and 7/15/2026, the medical provider's notes did not address the pharmacist's recommendation to consider discontinuing the loperamide hydrochloride. During an interview on 7/16/2026 at 12:06 p.m. with Pharmacist (Pharm) 2, Pharm 2 stated the medical providers are quick to respond in addressing any pharmacist recommendations to discontinue certain medications. Pharm 2 stated that if there was a pharmacist recommendation to discontinue Resident 22's loperamide on 6/24/2026, it should have been addressed already by the medical provider. During a concurrent interview and record review on 7/17/2026 at 1:02 p.m., reviewed Resident 22's physician's orders, eMAR, Pharmacy Monthly Chart Review, and medical provider's notes with Registered Nurse (RN) 2. RN 2 stated that the Pharmacy Monthly Chart Review dated 6/24/2026 indicated a recommendation to consider discontinuing loperamide hydrochloride. RN (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2 stated that Resident 22's medical provider's notes dated 7/1/2026, 7/2/2026, 7/6/2026, and 7/15/2026 did not address the pharmacy recommendation. RN 2 stated the medical providers are in the facility five (5) days a week. RN 2 stated that the medical providers had seen Resident 22 three (3) times since 6/24/2026 and reviewed the chart and should have addressed the pharmacy recommendation as the resident had a medication that is no longer needed. During a concurrent interview and record review on 7/17/2026 at 2 p.m., reviewed Resident 22's Pharmacy Monthly Chart Review dated 6/24/2026 and the medical provider's notes with the Chief Nursing Officer (CNO). The CNO stated that Resident 22's Pharmacy Monthly Chart Review indicated a recommendation to consider discontinuing the loperamide hydrochloride and was not addressed or acted upon by the medical providers. The CNO stated that the medical providers are in the facility 5 times a week and should be able to review the pharmacy recommendations in the electronic medical record (EMR). The CNO stated that Resident 22's pharmacist recommendation to discontinue the loperamide should have been addressed already as the resident had a medication that is no longer necessary. During a review of the facility's policy and procedure (P&P) titled, Drug Regimen Review, last reviewed on 3/2024 and approved by the governing body (a group of individuals or officials that holds ultimate authority and responsibility for overseeing the administration of an organization) on 6/2024, the P&P indicated that a pharmacist reviews each resident's EMR and checks medication orders for completeness and appropriateness using his clinical expertise in complying with the regulatory requirements. The P&P further indicated: - The drug regimen of each resident is assessed for appropriate medication use. - The pharmacist communicates in writing with the prescribers and nursing staff to note opportunities for drug therapy improvements via the Pharmacy Monthly Chart Review note in the EMR. - The pharmacist will follow up to determine that there is evidence that the prescriber responds to concerns raised by the Drug Regimen Review process. - Medications are discontinued when there is evidence that the resident has not taken the drug for some time and the drug could therefore be discontinued. - As needed drugs not used in the last 30 days will be re-evaluated for need and any unnecessary drugs will be discontinued.		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor resident dietary preferences for one of six sampled residents (Resident 23) reviewed during the Dining Observation task by failing to ensure the resident was provided milk and a banana for lunch on 7/13/2026. This failure had the potential to result in resident dissatisfaction leading to psychosocial issues resulting in decreased meal intake and unintentional weight loss. Findings: During a review of Resident 23's History and Physical (H&P), dated 11/25/2025, the H&P indicated the resident was admitted [DATE] with diagnoses that included dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), coronary artery disease (the buildup of plaque in the heart's arteries), and depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 23's Minimum Data Set (MDS - resident assessment tool) dated 7/10/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required supervision or touching assistance from staff for eating, oral and personal hygiene, toileting, bathing, mobility and dressing. During a review of Resident 23's Nutrition Risk Assessment (NRA), dated 10/20/2025, the NRA indicated the resident was at risk for weight loss due to dementia and depression. The NRA further indicated to provide the diet as ordered and monitor food intake During a review of Resident 23's Care Plan (CP) regarding nutrition, dated 11/29/2023, the CP indicated the resident had chronic conditions that may affect nutrition. The CP indicated a goal with a target date of 10/30/2026 that Resident 23 would be able to have the highest level of quality of life possible within the disease limitations. During a review of Resident 23's Monday Lunch Meal Ticket, the Monday Lunch Meal Ticket indicated Personal Menu Items: one (1) banana and 8.0 fluid ounces (fl. oz - a unit of measurement) whole milk. During a dining observation on 7/13/2026 at 12:24 p.m., with Resident 23, observed Resident 23 sitting at a dining table near HH East Nursing Station with the lunch tray in front of the resident. Resident 23 stated he did not always get the food he requested. Resident 23 stated for example, today he asked for a banana and milk and did not receive it. Reviewed the resident's Monday Meal Ticket indicated Personal Menu Items: 1 banana and 8.0 fl. oz whole milk and observed the resident's tray did not include a banana or milk. During a concurrent observation, interview, and record review on 7/13/2026 at 12:40 p.m., with Certified Nursing Assistant (CNA) 2, reviewed Resident 23's Monday Meal Ticket. CNA 2 stated the meal ticket indicated Resident 23 requested a banana and milk and the tray did not have a banana or milk on it. Observed CNA 2 then walked away to assist another resident. During an interview on 7/13/2026 at 12:45 p.m., with CNA 1, CNA 1 stated all the items on the meal ticket should be on the tray provided by the kitchen. CNA 1 stated sometimes the kitchen forgets to provide items on the meal tray and the CNA should call the kitchen to get the missing food. CNA 1 stated she had not called the kitchen for any missing items today. CNA 1 stated she provided Resident 23 his lunch tray and did not notice that anything was missing. During a concurrent observation, interview, and record review on 7/13/2026 at 12:48 p.m., with Restorative Nurse Assistant (RNA) 2, reviewed Resident 23's Monday Meal Ticket. RNA 2 stated when items are listed on the meal ticket, the kitchen should provide the items on the tray. RNA 2 stated Resident 23's meal ticket indicated a banana and milk, but a banana and milk were not provided. RNA 2 then walked down the hall to assist another resident and then returned and removed the resident's tray after the resident stated he was done eating. Observed RNA 2 did not call the (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Motion Picture and T.V. Hosp D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 23388 Mulholland Dr. Woodland Hills, CA 91364	
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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	kitchen to request the missing banana and milk. During a concurrent observation and interview on 7/13/2026 at 1 p.m., with CNA 1, in the hallway outside Resident 23's room, CNA 1 stated the kitchen should have provided Resident 23 with the banana and milk, but they did not. Observed CNA 1 entered Resident 23's room and asked the resident if he still wanted the banana and milk and the resident replied yes. CNA 1 stated she would call the kitchen to provide the banana and milk because it was the kitchen's fault for not providing them. During a concurrent interview and record review on 7/16/2026 at 8:27 a.m., with the Director of Hospitality (DH), reviewed the Policy and Procedure (P&P) regarding meal service. The DH stated the facility process is residents have the right to request food items. The DH stated the day prior to the meal service that the staff make rounds to review the menu and speak with the residents regarding their preferences. The DH stated when it is identified by a CNA that food is missing, they are responsible for calling the kitchen to ensure the food is provided. The DH stated Resident 23 had a request for a banana and milk for the 7/13/2026 lunch and the resident should have been provided with those items at lunch but was not. The DH stated the P&P was not followed when Resident 23 was not provided with a banana and milk during lunch potentially creating an issue with the resident that triggers behavioral symptoms that may negatively affect the resident's psychosocial wellbeing. During a review of the facility P&P titled, RESIDENT MEAL SERVICE, last revised 1/2026, the P&P indicated, Provide each resident with a nourishing, palatable, well-balanced, attractive meal, at a safe and appetizing temperature that meets their daily nutritional needs. Residents will be offered menu choices for all meals, beverages and snacks and are based on their prescribed diet, food preferences, allergies, intolerances, preferences and consistent with their plan of care. Promote independence and dignity by respecting each individual's culture, religious and ethnic preferences, and preferred dining schedule served in an environment that is as home-like as possible. PROCEDURES. Menu Choices.Offer choice and honor resident rights. Allow resident, family, resident representative and/or staff may make menu selections in advance based on food preferences and diet prescription. Meal Service and Dignity in Dining guidelines: . Provide dining in a home like environment that is appealing, safe and clean: .Utilize Menu tickets and/or diet extension report during meal service to ensure meal accuracy and resident safety.Monitor meals service to ensure timeliness and appropriateness. During a review of the facility provided Resource titled, Standard of Practice for Individualized Honoring Choices, dated 8/2011, the Resource indicated, Residents have the right to make an informed choice regarding their diet. The interdisciplinary team should work closely to develop a system promoting resident choice while maintaining quality of care. Choices with meaningful options in accordance with the person's preferences are offered to each resident numerous times daily.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to properly document the medical record for one of three sampled residents (Resident 66) by failing to accurately document resident's weight and documented 220 pounds (lbs., the standard unit of weight to measure how heavy something or someone is) on 3/07/2026. This failure has the potential to result in incomplete, inaccurate, or delayed records that could lead to miscommunication between healthcare providers and resident harm for Resident 66. Findings: During a review of Resident 66's Face Sheet (FS), the FS indicated the facility admitted the resident on 1/08/2026, with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), hyperlipidemia (high levels of fats in the blood), and dysphagia (difficulty swallowing) During a review of Resident 66's History and Physical (H&P), dated 1/08/2026, the H&P indicated that the resident has inability to comprehend and follow simple commands. During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 5/29/2026, the MDS indicated the resident was dependent (helper does all the effort) on all activities of daily living (ADLs, routine task/activity such as bathing, dressing and toileting a person performs daily to care for themselves), with substantial/maximal assistance (helper does more than half the effort) with transfers and repositioning. During a review of Resident 66's Care Plan (CP) titled, Nutrition/hydration dated 1/08/2026, the CP indicated interventions including monthly weights every month (.) and received and accept necessary assistance during and between meals with food and fluids. During a concurrent interview and record review on 7/17/2026 at 8:10 a.m. with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated that one of the CNAs responsibilities is to weigh residents based on the order, if weekly or monthly weigh checks. CNA stated after weighing the resident, she informs the nurse in charge of the resident, or she documents it herself in the electronic chart. CNA 1 stated that any questionable weight gain or weight loss must be rechecked and reported to the supervisor. CNA 1 stated that CNA 1 stated that documentation needs to be accurate because it will show in the medical record. During a concurrent interview and record review on 7/17/2026 at 8:12 a.m. with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated weights are documented by CNAs or LVNs in the electronic chart. LVN 1 upon record review of Resident 66's electronic chart stated the weight documented in the electronic chart on 3/07/2026 must be an error when the weight shown on the following 2/11/2026 of 127.2 lbs. / 57.70 kg; on 3/07/3036 222.0 lbs. / 100.70 kg; on 3/10/2026 124.6 lbs. / 56.52 kg; and on 4/01/2026 122.4 lbs. / 55.52 kg. LVN 1 stated there was no documentation that it was charted as an error and should have been corrected right away. LVN 1 stated documentation in electronic chart is important for residents to get appropriate care plans. During a concurrent interview and record review on 7/17/2026 at 10:01 a.m. with the Registered Dietician (RD), the RD stated that the documentation of 220 lbs. on 3/07/2026 for Resident 66 must be an error. The RD stated that documentation is important because it is a medical record. The RD stated the weight must be accurately documented to see if the weight gain is caused by edema, nutrition, or side effects of medication. The RD further stated that improper documentation could lead to not catching the real picture of nutritional status of the residents. During an interview and record review on 3/17/2026 at 2:25 p.m. with the Clinical Supervisor (CS), the CS stated that documentation is important because the treatment and plan of care is based on the documentation. The CS stated that the error in documentation of Resident 66's weight should have been corrected and should not have been ignored. The CS stated that the policy in documentation was not being followed. During a review of the facility's Policy and Procedures (P&P), (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Documentation, Nursing Weekly Summary reviewed on 12/04/2025, the P&P indicated to provide an accurate and concise summation of the resident's health status and review the Plan of Care. All areas of the Nursing Weekly Summary must be completed. Documentation of the Weekly Summary is completed in the Electronic Health Record (EHR). The Narrative Summary will include any changes of condition that have occurred in that week.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to implement the facility policy and procedure for one randomly observed resident (Resident 37) when Certified Nursing Assistant (CNA) 6 failed to doff (remove) disposable gloves and perform hand hygiene (HH - process of cleaning hands using soap and water or antibacterial hand rub) prior to exiting the resident's room after providing care with lift equipment (device used to assist with resident transfers). This failure had the potential to result in the spread of infectious microorganisms amongst staff, residents, and visitors. Findings: During a review of Resident 37's History and Physical (H&P), dated 1/7/2026, the H&P indicated the resident was admitted [DATE] with diagnoses that included heart failure (HF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), and hypertension (HTN - high blood pressure) During a review of Resident 37's Minimum Data Set (MDS - resident assessment tool) dated 7/7/2026, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for eating, oral and personal hygiene, toileting, bathing, and mobility. During an observation on 7/16/2026 at 3:50 p.m., observed CNA 6 in the hallway at MP [NAME] Nursing Station wearing disposable blue gloves. Observed CNA 6 obtained the lift equipment from the hallway and walked toward MP East Nursing Station. During a concurrent observation and interview on 7/16/2025 at 4:06 p.m. with CNA 6, observed CNA 6 exited Resident 37's room without performing HH and wearing blue disposable gloves while pushing the lift equipment down the hall. Observed CNA 6 placed the lift equipment at the side of the hallway, walked away from the lift equipment toward MP East Nursing Station, then removed the disposable gloves and placed them in the trash bin. CNA 6 stated she used the lift equipment to place Resident 37 in bed. CNA 6 stated she did not remove the gloves and perform hand hygiene after placing the resident in bed and exiting the room. CNA 6 then stated she wore disposable gloves in the hallway after providing care to Resident 37, but she should not have. CNA 6 stated it was important to remove the gloves and perform HH before exiting the resident's room for infection control and to prevent contamination from Resident 37's room to other residents. During an interview on 7/16/2026 at 4:20 p.m. with Registered Nurse (RN) 1, RN 1 stated gloves are considered dirty after providing resident care and should be immediately removed with HH performed prior to exiting the resident's room for standard precautions (an infection control measure aimed to prevent spread of infection). RN 1 stated disposable gloves should never be worn in the facility hallways after exiting a resident's room. RN 1 stated when CNA 6 did not follow standard precautions to remove the gloves and perform HH after providing care to Resident 37 and prior to exiting the room with the lift equipment, there was the potential for the spread of infections among staff and residents. During a concurrent interview and record review on 7/17/2026 at 2:05 p.m. with the Clinical Supervisor (CS), reviewed the facility policy and procedures (P&P) regarding HH, glove use, and standard precautions. The CS stated the facility P&P was not followed when CNA 6 did not remove used disposable gloves and perform hygiene prior to exiting Resident 34's room potentially resulting in resident infections when the CNA touched surfaces outside of the resident's room like the lift equipment that would then be used on other residents. During a review of the facility P&P titled, Hand Hygiene, last reviewed 10/2025, the P&P indicated, PURPOSE. To reduce the incidence of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	healthcare-associated infections. DEFINED. 1. Hand Hygiene is defined as the following: handwashing, or alcohol-based hand rub (ABHR). 1. All healthcare staff should comply with hand hygiene practices as defined in this policy. It is the single most important procedure for preventing healthcare associated infections . 3. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in the following clinical situation:. E. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient/resident. During a review of the facility P&P titled, Infection Precaution Techniques, last reviewed 10/2025, the P&P indicated, The policies and procedures for precaution techniques specify the minimal essential practices necessary for preventing transmission of infections. Hand hygiene is the single most important procedure for preventing HCA (healthcare-associated) infections. 2. Hand Hygiene using an alcohol-based hand gel should be utilized (when hands are not visibly soiled) in the following situations: . F. Any situation where microbial contamination of the hands is like to occur. 3. Hand Hygiene should be utilized, even when gloves are used. Hands hygiene should always be performed after glove removal. TO REMOVE GLOVES: Pull off from the cuff, turning inside out as they are removed. Wash hands or use hand gel before leaving the room. During a review of the facility P&P titled, LISTING OF CATEGORY-SPECIFIC ISOLATION PRECAUTION TECHNIQUES, last reviewed 10/2025, the P&P indicated, A. Standard Precautions: . Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in hospitals. 2. If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands after direct or indirect contact with the patient/resident and their environment.Gloves. Change gloves between tasks and procedures on the same patient after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces, and before going to another patient, and wash hands immediately to avoid transfer of microorganisms to other patients or environments.		