STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, interviews, and record reviews, the facility failed to provide residents' meals at regular times scheduled in accordance with resident needs, preferences, and requests when lunch was served late on 5/4/2026. This deficient practice had the potential to result in hunger and frustration affecting 88 to 91 residents who were getting food from the kitchen. Findings: During an observation on 5/4/2026 at 12:00 p.m., of the lunch trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to residents' plates) service, observed kitchen staff taking the temperatures of the foods using a facility thermometer. During an observation on 5/4/2026 at 12:24 p.m. of the lunch trayline, observed kitchen staff starting to dish out lunch trayline. During an observation on 5/4/2026 at 12:41 p.m., of the first meal cart for lunch, observed the kitchen staff delivered the cart outside the kitchen. During an observation on 5/4/2026 at 1:15 p.m. of the last meal cart for lunch, observed the kitchen staff left the kitchen to deliver the meal cart to the nurses' station. During an observation on 5/4/2026 at 1:21 p.m., of the tray passing, observed nursing staff passing the trays to the residents and the last tray was delivered to the residents at 1:25 p.m. During an interview on 5/4/2026 at 1:23 p.m. with the Dietary Supervisor (DS), the DS stated [NAME] 1 got confused with the easy-to-chew (foods that are soft) menu so it took him time to prepare and that she should have stepped in earlier. The DS stated the meals should be on time so that the residents would not get angry, frustrated, and file a grievance. During an interview on 5/4/2026 at 1:30 p.m., with the DS, the DS stated the food temperature was not good because of the delay in the trayline and residents could complain that the foods were cold. The DS stated the residents would not like the food as much, as a potential outcome of serving late meals. During a review of the facility's policy and procedure (P&P) titled, Frequency of Meals, dated 1/28/2026, the P&P indicated, Each resident shall receive at least three (3) meals daily, at times comparable to typical meal times in the community, or in accordance with resident's needs, preferences, requests and the plan of care. Policy interpretation and implementation: - The facility will serve at least three (3) meals or their equivalent at scheduled times. There will not be more than a fourteen (14) hour span between the evening meal and breakfast. - Meals will be served four (4) to six (6) hours apart to help ensure that residents receive nutritional requirements. The following mealtimes have been established by our facility for residents: - Breakfast 7 a.m. to 7:45 p.m. - Lunch 12:00 p.m. to 12:45 p.m. - Dinner 5:00 p.m. to 5:45 p.m.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 when: 1. Kitchen storage surfaces were not of cleanable surfaces a. Racks in the walk-in refrigerator had chips and the paint was coming off. b. Four (4) of 4 shelves in the reach-in refrigerator had rust and amber discoloration c. [NAME] shelves in the dry storage area had chips on the edges. d. Shelves in the walk-in freezer had rust and amber discoloration. e. Thirty-five (35) of 45 residents' trays had chips and cracks and lost its glaze. f. [NAME] chopping board by trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). 2. Kitchen and storage areas were not free from dirt and debris. a. Bottom reach -in refrigerator by trayline bottom shelves had dirt, dust and dried milk. b. Dry storage 1 (emergency supply) floors had dirt and dust debris. c. The dry storage 2 (paper supplies) floors had dirt and dust debris. d. Dry storage 3 (canned goods storage by the office) floors had dust, dirt and apple sauce container. e. Scoop drawer had dirt and food debris. f. Reach-in freezer shelves by the hallway had dirt, dust and food debris. 3. One (1) dented (a metal container with a depression or hollow made by pressure or impact) can was stored with non-dented cans. 4. Dietary Aide 1 (DA 1) was wearing a silver bracelet on her left hand and ring on her thumb and ring finger when cutting potatoes. 5. Improper thawing of pork chops when water was turned off and was at a temperature of 74.5 degrees Fahrenheit (F, a scale of temperature). 6. Dietary Aide 2 (DA 2) did not wash his hands when going from dirty to clean area. 7. Staff did not follow manufacturer's instructions when using test strips and checking the sanitizer concentration. 8. Staff did not follow the manufacturer's instructions when mixing sanitizer solution and water. 9. Facility did not monitor freezer temperature in the resident's freezer and ranges for refrigerator temperature was at danger zone of food. 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) affecting 88 of 91 medically compromised residents who received food and ice from the kitchen. Findings: 1a. During an observation on 5/4/2026 at 8:19 a.m., of the walk-in refrigerator, observed the shelves had chips and paint was coming off. During an interview on 5/4/2026 at 8:29 a.m., with the Dietary Supervisor (DS) the DS stated the shelves had rust and the coat was coming off. The DS stated it was important to have a smooth surface to prevent bacterial accumulation that could contaminate residents' food. The DS stated the shelves must be rust-free and debris-free to prevent cross-contamination. b. During an observation on 5/4/2026 at 8:23 a.m., of the reach-in refrigerator, observed 4 of 4 shelves had coats coming off and had amber discoloration. Observed the shelves had dirt and food debris on the bottom part. During an interview on 5/4/2026 at 8:29 a.m., with the DS, the DS stated the shelves had rust and coating coming off. The DS stated it was important to have racks and shelves with smooth surfaces to prevent bacteria accumulation that could cross-contaminate food. During an interview on 5/5/2026 at 9:22 a.m. with the DS, the DS stated that all the rusty racks were painted as a temporary fix as it was a special order. The DS stated the racks in the walk-in refrigerator and freezer were rusted and needed to be changed to prevent cross-contamination. During a review of the facility's policies and procedures (P&P) titled, Refrigerator and Freezers, dated 1/28/2026, the P&P indicated, 10. Supervisors inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. c. During a concurrent observation and interview on 5/4/2026 at 8:43 a.m., of the dry storage area with the DS, observed the wood storage rack had chips on the edge. The DS stated the wood storage rack would not be a cleanable surface because it was chipping and it could accumulate bacteria. The DS stated residents stated cross-contamination of food and food borne (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	illness would be the potential outcome for not having cleanable surfaces. d. During a concurrent observation and interview on 5/4/2026nat 9:47 a.m., of the walk-in freezer with the DS, observed the racks with amber discoloration. The DS stated it was not okay to have rust on the racks because it could cause cross-contamination of residents' food. e. During an observation on 5/4/2026 at 11:08 a.m. of the residents' trays, observed 35 of 45 trays had cracks, chips and lost its glaze. f. During an observation on 5/4/2026 at 11:43 a.m., of the white chopping board attached to trayline, observed the white chopping board had knife marks. During a concurrent observation and interview on 5/5/2026 at 9:34 a.m., of the cutting board attached in trayline, observed knife marks on the chopping board. The DS stated the chopping board by the trayline was worn out because it had visible scratches and it was no longer a cleanable surface causing potential bacterial growth. The DS stated the chopping board needed to be replaced to prevent cross-contamination. During a review of the facility's policies and procedures (P&P) titled, Sanitation, dated 1/28/2026, the P&P indicated, All utensils, counters and equipment are kept clean, maintained in good repair and free from breaks, corrosions, pen seams, cracks, and chipped areas that may affect their use or proper cleaning. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 4-501.12 Cutting Surfaces. Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may be transferred to foods that are prepared on such surfaces. 2.a. During an observation on 5/4/2026 at 8:23 a.m., of the reach-in refrigerator in the trayline area, observed dirt and food debris on the bottom shelves. During an interview on 5/4/2026 at 8:29 a.m., with the DS, the DS stated there was a white debris on the bottom shelves and it looked like dry milk. The DS stated the staff cleaned the refrigerator last Friday but needed to be clean to prevent cross contamination. The DS stated they clean when there are visible debris. b. During a concurrent observation and interview on 5/4/2026 at 8:43 a.m., of the dry storage floor with the DS, observed the corner floor had dirt, and dust debris. The DS stated the cleaning person did not clean properly and just pushed the dust and dirt on the edge of the floor. The DS stated it was important to maintain the cleanliness of the dry storage floor to avoid roaches and bacteria development causing cross contamination. c. During a concurrent observation and interview on 5/4/2026 at 8:51 a.m., of the dry storage area for paper supplies with the DS, observed the floor with dirt debris. The DS stated the floor needed to be cleaned as there was dirt and dust debris on the floor to prevent cross-contamination. The DS stated cross contamination could result in foodborne illness to the residents. d. During a concurrent observation and interview on 5/4/2026 at 9:02 a.m., of the dry storage area in the DS office with the DS, observed floors had dust and dirt and the apple sauce container was dusty to touch. The DS stated the dry storage area was dusty and the apple sauce container had dust and dirt. The DS stated it was important to maintain cleanliness of the dry storage area to prevent cross contamination of residents' food that could lead to foodborne illness. During a review of the facility's P&P titled, Food Receiving and Storage, dated 1/28/2026, the P&P indicated, Non-refrigerated food, disposable dishware and napkins are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. e. During a concurrent observation and interview on 5/5/2026 at 9:26 a.m., of the scoop drawer with the DS, observed the scoop drawer had dirt and food debris. The DS stated the dietary staff who cleaned the scoop drawer did a lousy job because it still had dirt. The DS stated it was important to clean the drawer where scoops were stored to prevent cross contamination. f. During a concurrent observation and interview on 5/5/2026 at 9:49 a.m., of the reach-in freezer outside the kitchen by the hallway with the DS, observed the bottom shelves had dirt and vegetable debris. The DS stated the dirt and vegetable debris needed to be cleaned to prevent cross contamination of residents' foods. During a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	review of the facility's P&P titled, Sanitation, dated 1/28/2026, the P&P indicated, The food service area is maintained in a clean and sanitary manner. 1. All kitchens, kitchen area and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. 3. All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical solution. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 3. During concurrent observation and interview on 5/4/2026 at 8:56 a.m., of the dry storage area of canned foods with the DS, observed one dented can stored with non-dented cans. The DS stated they need to separate dented cans from non-dented cans and place them on the bottom shelves to prevent residents from consuming them because of botulism (an illness caused by toxin produced by bacteria in dented cans). During a review of the facility's P&P titled, Food Receiving and Storage, dated 1/28/2026, the P&P indicated, Dry foods and goods are handled and stored in a manner that maintains integrity of the packaging until they are ready to use. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4. During an observation on 5/4/2026 at 9:08 a.m., of the food preparation, observed Dietary Aide 1 (DA 1) was wearing silver bracelet in her left hand and rings on her thumb and ring finger. During an interview on 5/4/2026 at 9:16 a.m., with the DS, the DS stated the staff were not allowed to wear jewelry in the kitchen and the dangling earrings are not allowed but they could have a wedding band. The DS stated the stones from the jewelry could accidentally go to the food as physical contaminants and body lotion and oils could accumulate in the jewelry causing cross contamination. During a review of the facility's P&P titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated 1/28/2026, the P&P indicated, 17. Jewelry will be kept to a minimum. Hand jewelry (e.g. rings) and wrist jewelry are kept covered with gloves during food handling. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. 5. During an observation on 5/4/2026 at 9:15 a.m., of the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preparation sink, observed meat in Ziplock thawing in the sink, the water was off, and the water temperature in the pan was at 75.4 degrees Fahrenheit (F, a scale of temperature). During a concurrent observation and interview on 5/4/2026 at 9:19 a.m., of the thawing porkchop in a pan with the DS, observed the water faucet was off. The DS stated they were thawing the pork chop because they needed it for lunch and it had to be in running water, but somebody turned the water off. The DS stated the water temperature of water was now below 70 F after turning it off but it did not have sufficient water velocity to loosen off particles. The DS stated it was important to thaw food properly to have safe temperatures because if the meat was in the danger zone (41 to 140 F, temperature where bacteria could grow and multiply quickly) for more than two hours it could cause foodborne illness to the residents. During a review of the facility's P&P titled, Food Preparation and Service, dated 1/28/2026, the P&P indicated, 1. Foods are not thawed at room temperature. Appropriate thawing procedures include: - Completely submerging the item in cold running water (70 F or below) that is running fast enough to agitate and remove loose ice particles. During a review of Food Code 22, dated 1/18/2023, the Food Code 2022 indicated, 3-501.13 Except specified in (D) of this section, Time/Temperature control for safety food shall be thawed: (B) Completely submerged under running water: (1) At a water temperature of 21 C (70 F) or below. (2) With sufficient water velocity to agitate and float off loose particles in an overflow, and (4) For a period of time does not allow thawed portions of a raw animal food requiring cooking as specified under 3-401.11 (A) or (B) to be above 41 for more than 4 hours including (a) the time the food is exposed to the running water and the time needed for preparation for cooking or (b) the time it takes under refrigeration to lower the food temperature to 5 C (41 F). 6. During an observation on 5/5/2026 at 11:28 a.m., of the Dietary Aide 3 (DA 3) dishwashing process, observed DA 3 scraped soiled dishes in the dirty area then dipped his hands in the red bucket then wiped it with a paper towel and put on gloves. Observed DA 3 went to the clean area and placed the clean dishes away to the storage area. During an interview on 5/5/2026 at 11:40 a.m. with DA 3, DA 3 stated he was going from dirty to clean and washed his hands using the red bucket with sanitizer. DA 3 stated he should have washed his hands in the sink because there were soap and water there. DA 3 stated he needed to wash his hands when going from dirty to clean and every time he changes his gloves for infection control. During an interview on 5/5/2026 at 11:57 a.m. with the DS, the DS stated kitchen staff needed to wash their hands in the handwashing station every time they were switching tasks, touching anything dirty, changing gloves and when going from dirty to clean during dishwashing. The DS stated DA 3 should not wash his hands using the red bucket because there was no running water and he did not scrub for 20 seconds. The DS stated DA 3 would be transferring bacteria from dirty dishes to the clean coffee pot and could result in cross contamination and foodborne illness. During a review of the facility's P&P titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 1/28/2026, the P&P indicated, Food and nutrition employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. 1. All employees who handle, prepare or serve food are trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. 6. Employee must wash their hands: - After handling soiled equipment and utensils. - After engaging in other activities that contaminate the hands. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); P (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	(F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. 7. During a concurrent demonstration observation and interview on 5/5/2026 at 2:22 p.m. of the quaternary ammonium (QUAT, a common chemical cleaner used to kill germs, bacteria and viruses) concentration testing with Dietary Aide 1 (DA 1), observed DA 1 got one test trip from the container then dipped the test strip for six (6) seconds (time from a wrist watch), then compared it in the color chart. DA 1 stated the QUAT sanitizer concentration was 200 parts per million (ppm, a unit of measurement to describe the concentration of a very dilute substance within a mixture) and it was an acceptable sanitizer concentration. DA 1 stated he knew he dipped the test strip because he counted 1, 2, 3, 4, and 5 in his head however he was maybe counting fast. DA 1 stated he did not check the water temperature, and he did not know that the sanitizer testing solution should be 67 to 75 F. DA 1 took the testing solution temperature using the facility thermometer. DA 1 stated the testing solution temperature was at 80 F. During a concurrent demonstration observation and interview on 5/5/2026 at 2:30 p.m., of the QUAT concentration testing with the DS, observed the DS filled the red bucket with sanitizer and water took the temperature. The DS stated the temperature of the QUAT sanitizer and water was 80 F. The DS stated the testing solution should be in the proper temperature to ensure that the test strip reads well for sanitizer concentration and to follow manufacturer's instructions. The DS stated not following the manufacturer's instructions could cause wrong reading of the test strip and wrong concentration of the sanitizer resulting for the sanitizer not to kill bacteria. During an interview on 5/5/2026 at 2:51 p.m. with the DS, the DS stated they were not following the manufacturers' guidelines for test strip for testing sanitizer because they were not taking the temperature of the testing solution hence the test strip may not be reading accurate sanitizer concentration. During an interview on 5/6/2026 at 9:49 a.m., with the Registered Dietitian (RD), the RD stated she was familiar with the manufacturer's instruction for the sanitizer test strips. The RD stated that following the manufacturer's instructions are necessary to ensure the sanitizer is not too strong and the reading might not be accurate. The RD stated if the test strip was not accurate it could pose a risk of cross contamination, food borne illnesses and stomach upset to the residents. During a review of the facility's test strip manufacturer's guidelines titled, Hydrion QT-40 Instructions- Lot 223825, dated 8/15/2027, the guidelines indicated, testing solution should be between 65-75 F. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. 8. During a concurrent demonstration and interview on 5/5/2026 at 2:47 p.m., of the sanitizer and water ratio mixture with the DS, observed the DS added three (3) pumps of sanitizer in the compartment sink. The DS stated she put 3 pumps of sanitizer in the compartment sink, but she was unsure how many sanitizers was 3 pumps. The DS stated she tested the solution based on experience and adjusted it to its proper ppm concentration by adding water or sanitizer until it reached the correct concentration of 200-400ppm. During a concurrent observation and interview on 5/5/2026 at 2:51 p.m., of the sanitizer concentration log on the wall with the DS, observed the log indicated to add half oz of QUAT sanitizer to two (2) gallons of water. The DS stated 3 pumps of QUAT sanitizer were around 90 ml or 3 oz. The DS stated they would be needing 12 gallons of water of 1/2 oz of QUAT sanitizer however the manufacturers' guidelines indicated 3 oz of QUAT sanitizer is to five (5) gallons of water. The DS stated the ratio posted on the log was wrong. The DS stated they were not following the dilution of the sanitizer to water and sanitizer may not be accurate concentration. The DS stated the sanitizer may not be killing bacteria and not sanitizing dishes causing foodborne illness. During an interview on 5/5/2026 at 3:27 p.m. with Dietary Aide 2 (DA 2), DA 2 stated the ratio of the sanitizer to water was 3 pumps and at least half water of the compartment sink but he did not know the exact amount of water to put. During (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	an interview on 5/6/2026 at 9:39 a.m. with the DS, the DS stated the dietary staff estimated the amount of water in the compartment sink and did not check water temperature of the testing solution. The DS stated they manually measure the amount of water in the two compartments sink to be 26.5 gallon and added 15.5 oz of sanitizer however the concentration was more than 400 ppm, so they needed to add more water to it. During an interview on 5/6/2026 at 10:03 a.m., with the RD, the RD stated they manually measured how much water in the two compartments sink yesterday and it was 26.5 gallons. The RD stated they added 15.9 oz of sanitizer. The RD stated the kitchen staff were estimating how much water and sanitizer mixture, and it was not okay. The RD stated it was important to follow the sanitizer manufacturer's guidelines, so the sanitizer is in the right concentration, and it is sanitizing the pots and pans properly to prevent cross-contamination. During a review of the facility's P&P titled, Sanitation, dated 1/28/2026, the P&P indicated, 3. The chemical solution is maintained at the correct concentration, based on periodic testing, at least once per shift, and for effective contact time according to manufacturer's guidelines. During a review of the facility's sanitizer direction for use titled, Sani Tech, undated, the direction for use indicated, Hospital disinfection: add 3.5 fluid oz of this product per 5 gallons of water dilution for disinfection against pseudomonas aeruginosa and vancomycin intermediate resistant staphylococcus aureus. General disinfection: add 3 oz of this product per 5 gallons of water (or equal dilution) for disinfection against staphylococcus aureus, listeria monocytogenes and Yersinia enterocolitica. 9. During an observation on 5/6/2026 at 9:23 a.m., of the residents' refrigerator in Station B with the DS, observed the freezer with no thermometer. During an interview on 5/6/2026 at 9:28 a.m., with the DS and Licensed Vocational Nurse 6 (LVN 6), LVN stated they monitor the resident's refrigerator to ensure its working to temperature of 36 to 46 F and they inform the maintenance when the temperature is not within the acceptable range. The DS stated the residents' refrigerator should be 41 F and below because 40 to 140 F is in the danger zone where bacteria grow faster on food. The DS stated the storage parameters were not acceptable. During an interview on 5/6/2026 at 9:32 a.m. with the DS, the DS stated the freezer needed to have another thermometer and the log did not indicate freezer temperature information. The DS stated that without freezer monitoring, the freezer could have been defrosted, and frozen food would not be frozen affecting the quality of food for the residents. During a review of the facility's P&P titled Refrigerator and Freezer, dated 1/28/2026, the P&P indicated, 1. Refrigerators and/or freezers are maintained in good working conditions. Refrigerators keep cold foods at/or below 41 F and freezer keep frozen foods frozen solid. 2. Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures. 5. The supervisor takes immediate action if temperatures are out of range. Actions necessary to correct the temperatures are recorded on the tracking sheet, including the repair personnel and/or department contacted. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-204.112 Temperature Measuring Devices.^^ (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a TEMPERATURE MEASURING DEVICE shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit. (B) Except as specified in (C) of this section, cold or hot holding EQUIPMENT used for TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be designed to include and shall be equipped with at least one integral or permanently affixed TEMPERATURE MEASURING DEVICE that is located to allow easy viewing of the device's temperature display.^^^ During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less.

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when: a. The dumpsters (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that specially designed garbage truck lifts) surroundings were not free of trash and dry black liquid spills. b. The dumpster covers have more than three inches (in., a unit of measurement) gap in between each other and not completely covered. c. The dumpster body had dry spills. These failures had potential to attract birds, flies, insects, pests (animals or microorganisms that has a negative effect on humans) and possibly spread infection to 91 of 91 facility residents. Findings: a. During an interview on 5/6/2026 at 9:02 a.m., with Dietary Aide 2 (DA 2), DA 2 stated he throws the kitchen trash and food trash in the dumpster after every meal. During an observation on 5/6/2026 at 9:05 a.m., of the dumpster outside the facility with the Dietary Supervisor (DS), observed soiled glove, paper and plastic cups on the surroundings floors. During a concurrent observation and interview on 5/6/2026 at 9:10 a.m., of the dumpster surrounding floors with Environmental Service Staff 1 (EVS 1), observed dry black liquid spills. EVS 1 stated they clean the dumpster surroundings once a month with a brush and a power wash however, they sweep the surroundings on daily basis. EVS 1 stated they want the dumpster area to be clean and trash not overflowing to prevent attracting insects, mice and termites. EVS 1 stated he cleans the dumpster surroundings once a day between 11:30 a.m. to 1:00 p.m. EVS 1 stated there was a space gap between the trash cover and pests could get in the trash. b & c. During a concurrent observation and interview on 5/6/2026 at 9:14 a.m. with the DS, the dumpster covers were observed. Observed Dumpster 1 had an in. gap in the middle of the dumpster and Dumpster 2 had more than three (3) inches gap causing both dumpsters not completely covered. The DS stated the dumpsters were not completely covered and it was not okay because pests could go in the trash and it is for infection control. During a concurrent observation and interview on 5/6/2026 at 9:16 a.m. with the Maintenance Supervisor (MS),the dumpster was observed. The Maintenance Supervisor (MS) observed the dumpster body had dry spills. The MS stated there were gaps between covers of the dumpster and it was not okay because flies could go in the dumpster and potentially having flies and rodents' infestation in the facility. The MS stated pests could bring diseases inside to the residents as a potential outcome. The MS stated there were black liquid spills on the floor and the body of the dumpsters had dry spills and needed to be cleaned to prevent the spread of infection to the residents. During a review of the facility's policies and procedures (P&P) titled, Food-Related Garbage and Refuse Disposal, dated 1/28/2025, the P&P indicated, Food-related garbage and refuse are disposed in accordance with current state laws. Policy Interpretation and Implementation: - All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use. - Garbage areas will be kept clean at all times and shall not constitute a nuisance. - Outside dumpster provided by garbage pick-up services will be kept closed and free of surrounding litter. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the (continued on next page)

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interviews, the facility failed to ensure that five of five sampled residents (Resident 36, 54, 75, 79, 97) were informed of the location of the results of the most recent survey of the facility conducted by Federal or State surveyors. This deficient practice resulted in resident being unable to access important facility information, potentially impacting their awareness of care standards, rights, and overall involvement in their care. Findings: 1. During a review of Resident 36's admission Records (AR - the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the AR indicated the facility originally admitted Resident 36 on 7/19/2024, then readmitted on [DATE], with diagnoses including malignant neoplasm of colon (large intestine cancer), sepsis (a life-threatening blood infection), chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing). During a review of Resident 36's History and Physical (H&P), dated 9/5/2026, the H&P indicated that the resident had the capacity to understand and make a decision. During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool) dated 4/20/2026, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated that Resident 36 was independent (resident completes the activity by themselves with no assistance from a helper) with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). 2. During a review of Resident 54's AR, the AR indicated that the facility originally admitted Resident 54 on 5/25/2020, then readmitted on [DATE], with diagnoses including spinal stenosis (the narrowing of the spaces in your spine (backbone), which puts pressure on the nerves and spinal cord running through it), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), peripheral vascular disease (PVD- a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 54's MDS, dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was intact. The MDS indicated that Resident 54 was dependent (helper does all of the effort) with toileting and personal hygiene, shoer, upper and lower body dressing, putting on/taking off footwear. 3. During a review of Resident 75's AR, the AR indicated that the facility admitted Resident 75 on 1/09/2020, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (a type ofˆischemic strokeˆwhere a blockage, cuts off blood supply to part of the brain), hypertension (high blood pressure), and alcohol abuse. During a review of Resident 75's MDS, dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was intact. The MDS indicated Resident 75 was dependent on toileting hygiene, showering and putting on/taking off footwear. Resident 75 required partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene, and upper body dressing. 4. During a review of Resident 79's AR, the AR indicated the facility admitted Resident 79 on 10/17/2025, with diagnoses including fracture of left fibula shaft (a break in the thin bone running down the outside of your lower left leg), dislocation of left ankle joint (a severe injury where the bones in your left foot and lower leg have been forced out of their normal alignment, tearing the ligaments that hold them together), and generalized muscle weakness. During a review of Resident 79's H&P, dated 12/3/2025, the H&P indicated that the resident had intact judgment and insight (a person understands their current situation and makes sound, safe decisions). During a review of Resident 79's MDS, dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was intact. The MDS indicated that Resident 79 was independent with eating, oral, toileting and personal hygiene, lower body dressing, putting on/taking off footwear and required supervision or touching assistance (helper provides verbal cues (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or touching/steadying and/or contact guard assistance as resident completes activity) with showering and upper body dressing. 5. During a review of Resident 97's AR, the AR indicated the facility originally admitted Resident 97 on 4/7/2025, then readmitted on [DATE], with diagnoses including surgical amputation (the removal of a limb or body part via surgery) of right leg above knee and left leg below knee, Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness. During a review of Resident 97's H&P, dated 8/4/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 97's MDS, dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was intact. The MDS indicated that the resident required partial/moderate assistance (helper does less than half the effort) with toileting hygiene and lower body dressing, and supervision or touching assistance with upper body dressing and personal hygiene. During an interview on 5/5/2026 at 1:59 p.m. in dining room, with Residents 36, 54, 75, 79, 97, during resident council meeting (a regular, resident-run gathering in assisted living or nursing homes where residents discuss life in the facility, share concerns, and make suggestions to staff to improve their quality of life), Residents 36, 54, 75, 79, 97 stated that they were unsure of the location of the results of the most recent survey of the facility conducted by Federal or State surveyors. During a concurrent observation and interview on 5/5/2026 at 2:20 p.m. with Activities Director (AD), the AD pointed the binder with the results of the most recent survey of the facility conducted by Federal or State surveyors located near the facility's main entrance by Nurses Station B. During an interview on 5/8/2026 at 1:51 p.m. with Director of Nursing (DON), the DON stated that binders with the results of the most recent survey of the facility conducted by Federal or State surveyors were located in the hallways, across from nurses' stations. The DON stated that all residents must know where to locate the binders with recent survey results. The DON stated that not knowing where to find the binder will result in lack of awareness of prior deficiencies and plans of correction, and overall performance, which can limit residents' ability to exercise their rights. During a review of facility's Policies and Procedures (P&P), titled Resident Rights, dated 1/28/2026, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to examine survey results.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely for four of nine sampled residents (Resident 31, 75, 37, and 49) reviewed under environment facility task by failing to: 1. Ensure Resident 31's headboard was fixed in a timely manner and was not loose and wobbly, creating a risk of the headboard falling on the resident. 2. Ensure Resident 75's battery compartment cover for the television (TV) remote control was not broken and did not have a rubber band used to hold the batteries in place. 3. Ensure Resident 37 and 49 had a functional dresser drawer. These deficient practices violated the resident's right to a safe, clean, comfortable and homelike environment.Findings: 1). During a review of Resident 31's admission Record (AR), the AR indicated the facility admitted the resident on 5/21/2020, and readmitted the resident on 12/12/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and mood disorder (is a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling). During a review of Resident 31's Care Plan (CP) Report regarding Resident 31's risk for falls related to a history of falls, hypertension (HTN, high blood pressure), atrial fibrillation (A-fib, is a common heart condition where the heart's upper chambers (atria) beat irregularly and very fast, rather than contracting effectively)., last revised on 5/1/2025, the CP indicated Resident 31 needs a safe environment. During a review of Resident 31's History and Physical (H&P), dated 6/6/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 31's Minimum Data Set (MDS, a resident assessment tool), dated 5/4/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in memory, thinking, or reasoning skills that goes beyond normal aging, making complex daily tasks difficult without causing full dependency). During a concurrent observation and interview on 5/4/2026, at 10:28 a.m., with Certified Nursing Assistant (CNA) 4, inside Resident 31's room, Resident 31's headboard was wobbly and was tilting towards the resident's head. CNA 4 stated it was not safe for the resident to have a wobbly headboard as it can fall on the resident's head causing bumps, bruises or even fractures (break in bone). CNA 4 stated she will call maintenance right away to fix the issue. During an interview on 5/6/2026, at 11:28 a.m., with the Assistant Director of Nursing (ADON), the ADON stated all staff are responsible for checking the resident's room for hazards and to promote a homelike environment. When the staff notice there is furniture or equipment that was not functioning properly, they need to report it to the maintenance department right away. The ADON stated the wobbly headboard could fall on the resident and cause accidents such as bumps, bruises or even fractures. The ADON stated the wobbly headboard is not promoting a homelike environment. The residents can feel uncomfortable with the environment and may feel unwelcome. During an interview on 5/7/2026, at 2:20 p.m., with the Director of Nursing (DON), the DON stated the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility failed to promote a homelike environment for Resident 31 by failing to ensure the wobbly headboard was fixed in a timely manner. The DON stated if it was the bed in the resident's home for sure they would have it fixed. The DON stated all staff were mandated to report broken, malfunctioning furniture or equipment in the facility to the maintenance Department to fix the furniture or equipment right away. The DON stated the presence of broken furniture can make the resident feel unwelcome. During a review of the facility's most recent policy and procedure (P&P) titled, Homelike Environment, last reviewed on 1/28/2026, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and are encouraged to use their personal belongings to the extent possible. During a review of the facility's recent P&P titled, Maintenance Service, last reviewed on 1/28/2026, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment.Policy Interpretation and Implementation1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.2. Functions of maintenance personnel include, but are not limited to:b. Maintaining the building in good repair and free from hazards.i. Providing routinely scheduled maintenance service to all areas.3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. 2). During a review of Resident 75's admission Records (AR - the front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted Resident 75 on 1/09/2020, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (a type of ischemic stroke where a blockage, cuts off blood supply to part of the brain), hypertension (high blood pressure), and alcohol abuse. During a review of Resident 75's Minimum Data Set ([MDS] - a resident assessment tool) dated 3/12/2026, the MDS indicated Resident 75 had a BIMS ([Brief Interview for Mental Status] - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (BIMS score 15 - a person's thinking, memory, and orientation are fully intact, indicating no significant cognitive impairment). The MDS indicated Resident 75 was dependent (helper does all the effort) with toileting hygiene, shower and putting on/taking off footwear. Resident 75 required partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene, and upper body dressing. During a concurrent observation and interview on 5/4/2026 at 12:36 p.m. with Resident 75 in Resident 75's room, Resident 75's TV remote control's battery compartment cover was observed broken, with a rubber band being used to secure the batteries. Resident 75 stated the TV remote control had been in this condition for the past two to three weeks. Resident 75 added that he had reported this to the facility staff multiple times and had been provided with rubber bands, to use, to hold the batteries in place. During a concurrent observation and interview on 5/4/2026 at 1:12 p.m. with Certified Nurse Assistant (CNA) 3, in Resident 75's room, CNA 3 stated that Resident 75's TV remote control was broken, and rubber bands were wrapped around the battery compartment to keep the batteries in place. CNA 3 stated that the broken TV remote control did not promote a home-like environment for Resident 75. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/2026 at 2:31 p.m. with the Director of Nursing (DON), the DON stated that it was important to provide residents with a homelike environment to support dignity and create a healing atmosphere. The DON stated a broken TV remote control could negatively affect Resident 75's sense of comfort and cause the resident to feel not at home. During a review of the facility's Policies and Procedures (P&P), titled Homelike Environment, dated 1/28/2026, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a clean, sanitary and orderly environment. 3). During A review of Resident 37's admission Record (AR), the AR indicated the facility originally admitted the resident on 8/19/2023 and readmitted on [DATE], with diagnoses including muscle weakness (Generalized) (weakness in many muscles throughout the body); and a history of falls; difficulty walking, not elsewhere classified (has trouble walking but exact cause has not been clearly identified). During a review of Resident 37's History and Physical (H&P), dated 5/15/2025, the H&P indicated the resident had the ability to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool), dated 3/16/2026, the MDS indicated the resident had the ability to usually make self-understood and usually understand others and had severe cognitive impairment (has major problems with memory, thinking, understanding, decision- making, and needs assistance with daily activities). The MDS indicated the resident required partial to supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent observation and interview on 5/4/2026, at 11:56 a.m., with Licensed Vocational Nurse (LVN) 3, inside Resident 37's room, LVN 3 observed that two drawers on the dresser were broken, one drawer belonged to Resident 37. LVN 3 stated that the drawers were not properly closing and were broken. LVN 3 notified maintenance immediately. During an interview regarding Resident 37 on 5/6/2026 at 2:30 p.m., with Registered Nurse (RN) 1, RN 1 stated when furniture is broken the residents do not feel welcome and it would not be promoting homelike environment. RN 1 stated Resident 37 would not feel safe and can possibly trip on the broken drawer. RN 1 stated the policy Homelike Environment was not followed. During an interview for Resident 37 on 5/7/2026 at 3:11p.m., The DON stated the residents would not be able to use broken furniture and the residents can get injured or harmed. 4). During a review of Resident 49's admission Record (AR), the AR indicated the facility originally admitted the resident on 3/26/2019 and was readmitted on [DATE], with diagnoses including hemiplegia, unspecified affecting left nondominant side (weakness or paralysis on left side of the body); type 2 diabetes mellitus without complications((a disorder characterized by difficulty in blood sugar control and poor wound healing); and essential hypertension (high blood pressure with no known specific cause). During a review of Resident 49's History and Physical (H&P), dated 3/6/2026, the H&P Indicated the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident had the ability to understand and make decisions. During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool), dated 3/23/2026, the MDS indicated the resident had the ability to make self-understood and to understand others and had moderate cognitive impairment (has some memory or thinking difficulties but can still communicate and participate in daily activities with some assistance and reminders). The MDS indicated the resident was dependent on supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent observation and interview on 5/4/2026, at 11:56 a.m., with Licensed Vocational Nurse (LVN) 3, inside Resident 49's room, LVN 3 observed two drawers of the dresser broken and one drawer belonged to Resident 49. LVN 3 stated that the drawers were not properly closing and were broken. LVN 3 notified maintenance immediately. During an interview regarding Resident 49 on 5/6/2026 at 2:30 p.m., with Registered Nurse (RN) 1, RN 1 stated when furniture is broken the residents would not feel welcome and it would not be promoting homelike environment. RN 1 stated Resident 49 would not feel safe and can possibly trip on the broken drawer. RN 1 stated the policy Homelike Environment was not followed. During an interview for Resident 49 on 5/7/2026 at 3:11p.m., the DON stated the resident would not be able to use broken furniture and the resident can become injured or harmed. During a review of the facility's Policies and Procedures (P&P), titled Homelike Environment, dated 7/24/2025, the P&P indicated, Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 1. Staff provides a person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences.2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. Clean, sanitary and orderly environment.

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure person centered care plans were developed and implemented for five of five sampled residents (Resident 53, Resident 14, Resident 4, Resident 31, and Resident 39) by failing to: 1. Monitor and assess Resident 53 for skin breakdown on affected sites. This deficient practice had the potential for recurrence of the pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device). 2. Develop and implement Resident 14's comprehensive care plan for oxygen administration.This deficient practice had the potential to result in failure of the delivery of necessary care and services.3. Develop and implement a care plan for Resident 4's clonazepam (medication used to calm the brain and nervous system) use.4. Develop and implement a care plan for Resident 31's Plavix use (medication commonly known as a blood thinner, though it works specifically by preventing blood cells called platelets from sticking together).5. Develop and implement a care plan for Resident 39's Hiprex (medication used to prevent or manage recurring urinary tract infections [UTIs - an infection in the bladder/urinary tract]).These deficient practices had the potential to result in a delay of nursing care and medical interventions for the residents.Findings: 1. During a review of Resident 53's admission Record (AR), the AR indicated that Resident 53 was initially admitted to the facility on [DATE] , with diagnoses including hypertension (high blood pressure), history of falling, cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body) and atrial fibrillation (an irregular and very rapid heart rhythm that and can lead blood clots in the heart). During a review of Resident 53's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ4/20/2026, the MDS indicated that Resident 53's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆintact. The MDS indicated Residentˆ53ˆrequired partial to substantial physical assistanceˆfrom staffs for activities of daily living (ADLs – toileting hygiene, shower/bathing).ˆThe MDS indicated the resident was at risk for developing pressure injuries. The MDS also indicated that Resident 53 had one stage 2 pressure ulcers (a shallow, open sore or blister) and two (2) stage 3 pressure ulcers (deep, open sore where the skin has fully broken down, exposing the fat layer underneath) that were present upon admission. During a review of Resident 53's History and Physical (H&P), H&P indicated that resident 53 had the capacity to understand and make decisions. During a review of Resident 53's Care Plan Report titled, possible wound recurrence of resolved left lateral buttock stage 2 pressure injury, left buttock stage 3 pressure injury and right buttock stage 3 pressure injury, initiated on 04/30/2026, the care plan indicated a goal to keep the skin intact by monitoring affected areas each shift and notifying the physician if breakdown occurs. During a subsequent review of Resident 53's Care Plan Report titled, at risk for pressure sore or potential for pressure ulcer development, revised on 4/16/2026, the care plan indicated a goal to minimize development of pressure injury by following facility's protocols for the prevention/treatment of skin breakdown. During an interview on 5/6/2026 at 1:10 p.m. with Resident 53, Resident 53 stated developing a pressure ulcer upon admission to an acute care hospital. During a concurrent observation, interview and record review on 5/6/2026 at 1:12 p.m. with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Treatment Nurse (TN) 2, Resident 53's physician's order recap report, skin issues assessment and care plan report were reviewed. TN 2 observed assessing the buttocks and he stated describing the buttocks as blanchable pinkish redness with dry, intact skin. TN 2 stated that there was a care plan for Resident 53 to monitor affected areas every shift, although it was not implemented. TN 2 emphasized the importance of monitoring healed pressure injuries due to the risk of reopening from weakened adipose tissue (body fat). TN 2 added that lack of continuous monitoring could result in worsening conditions before detection. During an interview on 5/6/2026 at 2:44 p.m. with Registered Nurse (RN) 1, RN 1 stated that the care plan provides structure for resident care. RN 1 added that the staff use it to monitor progress, prevent complications, and address issues. RN 1 further stated that not following the care plan may worsen the resident's condition. During an interview on 5/7/2026 at 2:12 p.m. with the Director of Nursing (DON), the DON stated a care plan was designed to address a resident's specific problem to reach a defined goal. The DON explained that adhering to the care plan increases the likelihood of achieving that goal and resolving the issue. The DON further stated that failing to follow the care plan may result in the goal not being met and the problem continuing. During a review of facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries reviewed on 01/28/2026, the P&P indicated that ongoing monitoring requires evaluating, reporting, documenting skin changes, and regularly assessing the effectiveness of interventions. 2. During a review of Resident 14's AR, the AR indicated the facility admitted the resident on 4/14/2026, with diagnoses including other pulmonary embolism without acute cor pulmonale (a blood clot in the lungs that is blocking blood flow, but is not severely affecting the heart at this time); muscle weakness (generalized) (weakness in many muscles throughout the body); obesity, class 2 (weighs much more than what is considered healthy for their height). During a review of Resident 14's H&P, dated 4/16/2026, the H&Pˆindicatedˆthe resident had mental capacity, alert, oriented to person, place, and situation. During a review of Resident 14's MDS, dated [DATE], the MDS indicated Resident 14 had the ability to make self- understood and understand others and had intact cognitive function (normal thinking). The MDS indicated the resident was dependent to partial assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 14's Order Summary Report (OSR), dated 4/15/2026, the OSR indicated an order for oxygen at 2 liter/min via Nasal Cannula (N/C- a small plastic tube with 2 tips that go in the nose to deliver oxygen from an oxygen source) continuously. May titrate (adjust) to maintain oxygen saturation greater than 92% During a concurrent interview and record review for Resident 14 on 5/6/2026 at 2:30p.m., with RN 1, reviewed ORS and care plans but RN1 was unable to find care plan for oxygen. RN 1stated there was no care plan for oxygen administration. RN 1 stated the care plan is guide that guides nurses to see if current oxygen is effective or not and to continue monitoring and if not effective then need to notify physician. RN 1 stated the care plan was not done and the policy titled, Care Plans, Comprehensive Person-Centered, was not followed.ˆ During an interview on 5/7/2026 at 3:11p.m., with the DON stated that an OSR and care plan needs to be done for oxygen for Resident 14. The DON stated for Resident 14 the care plan is important to have because it addresses care of the resident. 3. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 11/14/2025, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), anxiety disorder (are mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with daily life), and auditory hallucinations (sensory experiences where a person hears voices, noises, or music that do not exist in reality). During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had moderate cognitive impairment (a stage of brain decline between normal aging and dementia, where a person experiences noticeable memory or thinking issues that interfere with daily life, but they can still largely take care of themselves). The MDS indicated the resident was on a high-risk drug class antipsychotic medication (prescription medications used to treat symptoms of psychosis—such as hallucinations, delusions, and disorganized thinking—by altering brain chemistry, typically by blocking dopamine receptors). During a review of Resident 4's OSR, dated 4/12/2026, the OSR indicated an order for Clonazepam oral tablet 0.5 milligrams (mg - a unit of weight) (Clonazepam). Give 0.6 mg by mouth one time a day for anxiety monitor for behavior (m/b) agitation. During a concurrent interview and record review on 5/6/2026, at 2:52 p.m., with the Assistant Director of Nursing (ADON), reviewed Resident 4's OSR and Care Plans (CP). The ADON stated there was no care plan on Resident 4's use of Clonazepam. The ADON stated it was important to have a care plan on the use of Clonazepam to outline the problem, the goal and interventions needed to be provided to the resident. The ADON stated the CP serves as a communication to all healthcare providers to coordinate care. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated the care plan was needed to address the problem and by identifying the problem they create specific interventions to achieve the goal of the problems. The DON stated if the care plan was present everybody will be on top of the care and they will be able to provide ideal/appropriate care for the residents. 4. During a review of Resident 31's AR, the AR indicated the facility admitted the resident on 5/21/2020, and readmitted the resident on 12/12/2025, with diagnoses including paroxysmal atrial fibrillation, presence of a cardiac pacemaker (a small, battery-powered device—roughly the size of a matchbox or a large vitamin capsule—that is implanted under the skin, usually just below the collarbone, to help manage an irregular or slow heartbeat), and gastro-esophageal reflux disease (GERD - a chronic, more severe form of acid reflux). During a review of Resident 31's H&P, dated 6/6/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 31's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment. During a review of Resident 31's OSR, dated 12/13/2025, indicated an order for Plavix Oral Tablet 75mg (Clopidogrel Bisulfate). Give 1 tablet by mouth one time a day for cerebrovascular accident prophylaxis (CVA PPX, taking active steps to prevent a stroke (Cerebrovascular Accident or CVA) before it happens, or to prevent a second one). During a concurrent interview and record review on 5/6/2026, at 11:30 a.m., with the ADON and RN 2, Resident 31's OSR and CPs were reviewed. The ADON and RN 2 stated there was an order for Plavix and monitoring for its adverse effects (an unwanted, harmful, or unexpected reaction caused by a medical treatment (like a drug or surgery) however, there was no specific care plan for Plavix. The ADON and RN 2 stated Plavix has a block box warning (usually the things that we need to focus on and monitor for, like fetal toxicity, resp distress for narcotics). The ADON and RN 2 stated without a care plan, they will not be able to monitor the serious adverse effects of the medication. During an interview on 5/7/2026, at 2:20 p.m. with the DON, the DON stated the care plan was needed to address the problem and by identifying the problem they create specific interventions to achieve the goal of the problems. The DON stated if the care plan was present everybody will be on top of the care and they will be able to provide ideal/appropriate care for the residents. 5. During a review of Resident 39's AR, the AR indicated the facility admitted the resident on 8/22/2016, and readmitted the resident on 2/17/2025, with diagnoses including pneumonia (an infection/inflammation in the lungs), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and hemiparesis (weakness on one side of the body). During a review of Resident 39's H&P, dated 2/18/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 39's MDS, dated [DATE], (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the MDs indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities—such as memory, thinking, reasoning, and attention—are functioning normally and without significant impairment). The MDS indicated the resident was frequently incontinent of urine and stool (feces). During a review of Resident 39's OSR, dated 3/20/2025, the OSR indicated an order for Hiprex oral tablet 1 gm (Methenamine Hippurate). Give 1 gm by mouth 2 times a day for UTI PPX. During a concurrent interview and record review on 5/6/2026 at 1:30 p.m. with the ADON, Resident 39's OSR and CPs were reviewed. The ADON stated there was no care plan developed and implemented on the use of Hiprex on Resident 39. The ADON and RN 2 stated without a care plan, they will not be able to monitor the serious adverse effects of the medication. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated the care plan was needed to address the problem and by identifying the problem they create specific interventions to achieve the goal of the problems. The DON stated if the care plan was present everybody will be on top of the care and they will be able to provide ideal/appropriate care for the residents. During a review of the facility's recent P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/28/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated that care plan interventions are selected after data collection and clinical judgment, considering the resident's issues and their causes. The P&P also indicated that resident assessments are continuous, and care plans are updated as conditions change. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards of care for two of two sampled residents (Residents 76 and 39) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted the resident on 6/9/2023, and readmitted the resident on 8/4/2025, with diagnoses including type two (2) diabetes mellitus (DM2, a disorder characterized by difficulty in blood sugar control and poor wound healing), adult failure to thrive (a rapid, snowballing decline in an older person's physical or mental health that cannot be blamed on one single disease), and dysphagia (difficulty swallowing). During a review of Resident 76's History and Physical (H&P), dated 8/5/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated the resident usually had the ability to make self-understood and usually had the ability to understand others and had severe cognitive impairment (a profound loss of mental capacity-comparable to advanced dementia or Alzheimer's-where a person can no longer live independently, manage daily tasks (like eating or dressing), communicate effectively, or understand their surroundings). The MDS indicated that the resident was on a high-risk drug class hypoglycemic medication (treatments designed to quickly raise blood sugar levels when they drop dangerously low). During a review of Resident 76's Order Summary Report (OSR), dated 12/6/2025, the OSR indicated an order for Insulin Aspart (a fast-acting insulin) Pen Fill Subcutaneous Solution Cartridge 100 units per milliliters (unit/ml, describes the concentration of insulin, defining how much medication is packed into the liquid) (Insulin Aspart). Inject as per sliding scale (a flexible pricing system where costs, fees, or wages change based on a person's ability to pay, income level, or specific conditions): if 70 - 149 = 0 UNIT If blood sugar (BS) is less than (<) 70 give orange juice (OJ) if awake and able to swallow then notify MD; 150 - 199 = 1 unit; 200 - 249 = 2 units; 250 - 299 = 3 units; 300 - 349 = 4 units greater than (>)349=5 UNITS then call MD, subcutaneously four times a day for DM2 Rotate injection sites. During a review of Resident 76's Location of Administration Report (LAR) for Insulin for 4/2026, the LAR indicated that insulin was subcutaneously given on: Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 UNIT/ML 4/1/2026 at 7:06 a.m. on the Abdomen - Left Upper Quadrant (LUQ) 4/2/2026 at 7:10 a.m. on the Abdomen - LUQ 4/15/2026 at 9:53 p.m. on the Abdomen - LUQ 4/16/2026 at 4:46 p.m. on the Abdomen - LUQ 4/24/2026 at 7:09 a.m. on the Abdomen - Right Upper Quadrat (RUQ) 4/24/2026 at 4:46 p.m. on the Abdomen - RUQ During a review of Resident 76's Care Plan (CP) Report titled, The resident has Diabetes Mellitus, last revised on, the CP indicated an intervention to rotate injection sites. During a concurrent interview and record review on 5/6/2026, at 11:44 a.m., with the Assistant Director of Nursing (ADON), Resident 76's OSR, LAR, and CPs were reviewed. The ADON stated there was an order from the physician to rotate sites of administration of the insulin. The ADON stated Resident 76`s LAR for 4/2026 indicated that the resident`s insulin administration sites were repeated. The ADON stated the P&P titled Insulin Administration, was not followed. The ADON stated that licensed staff are rotating sites of insulin administration to prevent lipodystrophy on residents. The ADON added administering medications to sites of lipodystrophy may affect the absorption of the insulin and may cause hypo/hyperglycemia to residents. During an interview on 5/7/2026, at 2:20 p.m., with the Director of Nursing (DON), the DON (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the sites of administration of insulin for Resident 76 should be rotated to avoid infection and trauma to the site. The DON stated frequently administering insulin on the same site hardens the skin of the area which causes lipodystrophy. The DON stated that administering insulin on the site of lipodystrophy will have impaired absorption. The DON stated the resident can suffer from hypo (low)/hyperglycemia (high blood sugar level). During a review of Resident 39's AR, the AR indicated the facility admitted the resident on 8/22/2016, and readmitted the resident on 2/17/2025, with diagnoses including DM2, morbid obesity (is a serious, chronic disease defined as having a body mass index (BMI) of 40 or higher, or being 100 pounds or more over ideal body weight), and dysphagia. During a review of Resident 39's H&P, dated 2/18/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 39's Order Summary Report (OSR), the OSR indicated an order for: 2/17/2025 Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 unit/ml (Insulin Aspart). Inject as per sliding scale: if 200 - 250 = 2 units if BS is < 70 Give OJ if awake and able to swallow then notify MD; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units >500 CALL MD, subcutaneously before meals and at bedtime for DM Rotate injection sites. 2/18/2025 Insulin Glargine (a long-acting insulin) Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 30 unit subcutaneously two times a day for DM. Rotate injection site; Hold if BS is < 100, notify MD if BS is < 60 or > 400. During a review of Resident 39's Care Plan (CP) Report titled, Resident is at risk for hypoglycemia and hyperglycemia related to Diabetes Mellitus, initiated on 6/20/2018, the CP indicated an intervention to rotate the injection site. During a review of Resident 39's LAR of Insulin for 4/2026, the LAR indicated that insulin was subcutaneously given on: Insulin Glargine Subcutaneous Solution Pen injector 100 unit/ml 4/14/2026 at 8:02 a.m. on the Abdomen - LUQ 4/15/2026 at 5:20 p.m. on the Abdomen - LUQ 4/27/2026 at 8:06 a.m. on the Abdomen - Right Lower Quadrant (RLQ) 4/27/2026 st 6:55 p.m. on the Abdomen - RLQ Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 unit/ml 4/4/2026 at 12:59 p.m. on the Abdomen - RLQ 4/4/2026 at 10:19 p.m. on the Abdomen - RLQ During a concurrent interview and record review on 5/6/2026, at 11:44 a.m., with the ADON, Resident 39's OSR, LAR, and CPs were reviewed. The ADON stated there was an order from the physician to rotate sites of administration of the insulin. The ADON stated Resident 39`s LAR for 4/2026 had repeated administration sites. The ADON stated the P&P titled Insulin Administration, was not followed. The ADON stated that they were rotating sites of administration to prevent lipodystrophy on residents. The ADON added administering medications to sites of lipodystrophy may affect the absorption of the insulin and may cause hypo/hyperglycemia to residents. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated the sides of administration of insulin for Resident 39 should be rotated to avoid infection and trauma to the site. The DON stated frequently administering insulin on the same site hardens the skin of the area which causes lipodystrophy. The DON stated that administering insulin on the site of lipodystrophy will have impaired absorption. The DON stated the resident can suffer from hypo/hyperglycemia. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed 1/28/2026, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided A Step-by-Step Guide to Using Your Lantus SoloStar Pen, copyright 2022, the Guide indicated to change (rotate) your injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval on 2000, the HPI indicated to rotate injections sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis.^

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for seven of thirteen sampled residents (Residents 4, 76, 110, 15, 31, 29, and 113) reviewed for accidents by failing to:1. Ensure Resident 4 and 29's beds were kept at the lowest position.2. Ensure Resident 76's floor mat was not placed halfway under the bed.3. Ensure Resident 110's bed remote control was within reach.4. Ensure Resident 15 did not have a bottle of hand sanitizer at the bedside.5. Ensure Resident 31 did not have a wobbly headboard that could fall on the resident's head.6. Ensure the compartments containing hazardous chemicals, such as Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes (fast-acting, hospital-grade cleaning wipes that kill 99.9% of bacteria and viruses in as little as thirty (30) seconds) and Clorox Healthcare Bleach Germicidal Cleaner (a strong, ready-to-use hospital-grade disinfectant spray designed to kill 99.9999% of tough germs and viruses, in 3 minutes or less) were secured and locked when EVS staff were not present on two of two Environmental Services (EVS) carts (a specialized, mobile cleaning workstation used by housekeeping staff in hospitals and healthcare facilities to clean and disinfect rooms, preventing the spread of germs).7. Ensure Resident 113 did not have any medications left at the resident's bedside.These deficient practices increase the risk of accidents such as falls with injuries, poisoning, and electrocution of residents. Findings: 1). During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2025, with diagnoses including hearing loss, contracture (a permanent tightening or shortening of muscles, tendons, skin, or tissues around a joint), and auditory hallucinations (the perception of sounds, noises, or voices that exist only in a person's mind, not in reality). During a review of Resident 4's Admission/readmission Data Tool (ADT), dated 11/4/2025, the ADT indicated the resident was at risk for falls. During a review of Resident 4's Care Plan (CP) Report titled, Resident uses grab bars/mobility bars on both sides of bed for turning and repositioning, last revised on 4/22/2026, the CP included an intervention to keep the bed in the lowest position when not actively repositioning the resident.During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/27/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understands others and had moderate cognitive impairment (a stage of brain decline between normal aging and dementia, where a person experiences noticeable memory or thinking issues—such as forgetting appointments, repeating stories, or trouble navigating—but can still manage daily routines without needing daily help). The MDS indicated the resident was dependent to needing partial assistance in mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 5/4/2026, at 10:19 a.m., with Licensed Vocational Nurse (LVN) 3 and Certified Nursing Assistant (CNA) 2, inside Resident 4's room, Resident 4's bed was observed in a high position. LVN 3 and CNA 2 both stated the bed was high. CNA 2 measured the height of the bed from the floor to the mattress surface and recorded 27. 5 inches off the floor. LVN 3 stated the bed was high and usually the height of the low beds were only 12 inches below. LVN 2 stated that the failure of the staff to bring the bed down to the lowest position predisposed the resident to accidents such as falls with injury. LVN 2 stated the higher the bed was, the higher the likelihood of the resident sustaining a fall with injury. (continued on next page)

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/6/2026, at 2:49 p.m., with the Assistant Director of Nursing (ADON), Resident 4's ADT and CP were reviewed. The ADON stated the bed of Resident 4 should be kept at the lowest position to prevent falls with injury. The ADON stated the policies and procedures titled Safety and Supervision of Residents and Falls and Fall Risk, Managing, were not followed by the facility and the Manufacturer's Specification provided by the facility titled, Drive Bed Operation, was not followed. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated the bed of Resident 4 should be placed at the lowest possible position. The DON stated the bed height should always be less than 24 inches from the floor to prevent injuries. The DON stated the care plan was not followed. During a review of the facility's recent policy and procedure (P&P) titled, Falls and Fall Risk, Managing, last reviewed on 1/28/2026, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Policy Interpretation and ImplementationFall Risk Factors1. Environmental factors that contribute to the risk of falls include:c. incorrect bed height or width. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/28/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and ImplementationFacility-Oriented Approach to Safety4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.Individualized, Resident-Centered Approach to Safety5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions.Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:a. Bed Safetyc. Fallsf. Poison Controlg. Electrical Safety During a review of the facility-provided Drive Bed Operation, revised on 5/2025, the Operation indicated under initial Start Up (Bed Synchronization)-Lower the bed to near the lowest position. During a review of Resident 29's admission Record (AR), the AR indicated the facility originally admitted the resident on 1/17/2019 and readmitted on [DATE], with diagnoses including muscle weakness (Generalized) (weakness in many muscles throughout the body); unspecified dementia, (unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance), and anxiety (has memory loss, problems with thinking or daily functioning, but the exact type and severity are unknown, and the person is not showing behaviors such as aggression, severe mood changes, and anxiety); acquired absence of right leg above knee (the surgical removal of the leg above the knee joint). During a review of Resident 29's History and Physical (H&P), dated 11/18/2025, the H&P indicated the resident has the capacity to make decisions. During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 2/10/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognitive function (normal thinking). The MDS indicated the resident required (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependent supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 29's Quarterly Risk Data Collection Tool (QRDCT), dated 2/11/2026, the QRDCT indicated resident is at risk for falls. During a concurrent observation and interview on 5/4/2026, at 12:44 p.m., with Certified Nursing Assistant (CNA) 7, in Resident 29's room, Resident 29's bed was observed in a high position. CNA 7 stated the resident has the ability to control the bed and likes the bed in high position. CNA7 measured with a measuring tape from floor to top of mattress and CNA 7 stated the height of the bed measured 31 inches away from the floor. During a concurrent interview and record review for Resident 29 on 5/7/2026, at 2:00 p.m., with Registered Nurse, (RN) 1, was unable to find any physician order or care plan indicating to place Resident 29's bed in a high position. RN 1 stated there was no physician order or care plan for high bed position for Resident 29. RN 1 reviewed the QRDCT and stated the resident was at risk for falls. RN 1 stated the bed should be placed at the lowest position possible to prevent injuries or a fall, especially if the resident is at risks for falls. During a concurrent interview and record review on 5/7/2026, at 3:00 p.m., with the Assistant Director of Nursing (ADON), the ADON was unable to find a physician order or care plan to place the bed in a high position. The ADON stated if the residents prefer to have the bed in high position, there needs to be a care plan. The ADON reviewed QRDCT dated 2/11/26, and stated the resident was at risk for falls. The ADON stated that the resident can potentially fall if the bed is in high position. The ADON stated the staff should have kept the bed at the lowest position to prevent falls with injury. The ADON stated that the care plan intervention is used to prevent falls. During a review of the facility's Policy and Procedure titled, Falls and Fall Risk, Managing, last reviewed on 1/28/2026, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Policy Interpretation and ImplementationFall Risk Factors1. Environmental factors that contribute to the risk of falls include:c. incorrect bed height or width. 2). During a review of Resident 76's AR, the AR indicated the facility admitted the resident on 6/9/2023, and readmitted the resident on 8/4/2025, with diagnoses including difficulty in walking, lack of coordination, and muscle weakness. During a review of Resident 76's H&P, dated 8/5/2025, the H&P indicated the resident does not have the capacity to make decisions.During a review of Resident 76's ADT, dated 12/5/2025, the ADT indicated the resident was at risk for falls. During a review of Resident 76's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually had the ability to understand others and had severe cognitive impairment (a profound loss of mental capacity—such as memory, reasoning, and communication—that makes it impossible for a person to live independently or care for themselves). The MDS indicated the resident was dependent to needing partial assistance in mobility and activities of daily living (ADLs). The MDS further indicated that the resident had fallen in the last 2-6 months. During a review of Resident 76's CP Report titled, Resident with landing pad on the left side, initiated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manner, style, or pattern of walking or running) and mobility, and muscle weakness. During a review of Resident 110's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a profound, often irreversible loss of mental capacity where a person can no longer live independently or manage their own affairs). The MDS indicated the resident was dependent to needing substantial assistance in mobility and ADLs.During a review of Resident 110's ADT, dated 4/24/2026, the ADT indicated the resident was not at risk for falls. During a review of Resident 110's H&P, dated 4/26/2026, the H&P indicated the resident was awake, alert, oriented, responding to yes/no questions appropriately, moving all extremities, cranial nerve intact, right-sided upper and lower extremity weakness. During a review of Resident 110's CP Report titled, The resident is at risk for Falls related to hemiplegia and hemiparesis following cerebral infarction . impaired physical mobility and history of fall, last revised on 4/25/2026, the CP included an intervention indicating the resident needs a safe environment with even floors, free from spills, and/or clutter, adequate, glare-free light; a working and reachable call light and personal items within reach). During a concurrent observation and interview on 5/4/2026, at 10:19 a.m., with LVN 3, inside Resident 110's room, Resident 110's bed remote control was observed on the floor. LVN 3 stated the bed remote control should always be within the reach of the resident so they can adjust their positioning in bed according to their comfort. During a concurrent interview and record review on 5/6/2026, at 1:47 p.m., with the ADON, Resident 110's ADT and CP were reviewed. The ADON stated the resident is at risk for falls, however on 4/24/2026 Admission/Readmission/readmission Data Tool the resident was not at risk for falls. The ADON stated there was a potential for the resident to fall while reaching for the bed remote control on the floor. The ADON stated the failure of the staff to keep the bed remote control within reach can lead to resident discomfort while in bed because the resident will not be able to adjust the bed according to his comfort. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated the bed remote control of Resident 110 should have been picked up and disinfected and placed back on the bed so the resident can reach them. The DON stated all staff are responsible for ensuring the bed remote control is within reach of the resident when they perform their environmental safety rounds. The DON stated the failure of the staff to keep the bed remote control within reach can lead to resident discomfort due to the resident being unable to change the position of the bed for comfort. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/28/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and ImplementationFacility-Oriented Approach to Safety4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.Individualized, Resident-Centered Approach to Safety5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions.Resident Risks and Environmental Hazards1. Due to their complexity and scope, certain resident risk factors and environmental; hazards are addressed in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dedicated policies and procedures. These risk factors and environmental hazards include the following:a. Bed Safety;c. Falls;f. Poison Control;g. Electrical Safety. During a review of the facility's recent P&P titled, Falls and Fall Risk, Managing, last reviewed on 1/28/2026, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.Policy Interpretation and ImplementationFall Risk Factors1. Environmental factors that contribute to the risk of falls include:c. incorrect bed height or width. 4). During a review of Resident 15's AR, the AR indicated the facility admitted the resident on 6/27/2017, and readmitted the resident on 10/15/2018, with diagnoses including muscle wasting and atrophy (the wasting away, shrinking, or loss of size and strength in body tissues or muscles), lack of coordination, and muscle weakness. During a review of Resident 15's H&P, dated 10/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 15's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually had the ability to understand others and had severe cognitive impairment. During a concurrent observation and interview on 5/4/2026, at 10:53 a.m., with the Activities Director (AD), inside Resident 15's room, a big bottle of hand sanitizer was left at the bedside of the resident. The AD stated the bottled of hand sanitizer should not be left at the resident's bedside for safety. The AD stated that the resident or other confused resident can ingest the sanitizer which can cause adverse reactions to the residents. During a concurrent interview and record review on 5/6/2026, at 10:34 a.m., with the ADON, Resident 15's MDS and CP were reviewed. The ADON stated that all staff should detect hazards in the resident's environment such as the big bottle of hand sanitizer left at the bedside because the resident has dementia and can ingest the sanitizer which can cause adverse reactions to the resident. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated the big bottle of hand sanitizer should not be left at Resident 15's bedside, as the resident could ingest them due to confusion and cause adverse reactions to the resident. The DON stated it was the responsibility of all staff to ensure the environment of the resident was free from hazards. The DON stated the staff should have removed them as soon as they saw them. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/28/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and ImplementationFacility-Oriented Approach to Safety4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.Individualized, Resident-Centered Approach to Safety5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions.Resident Risks and Environmental Hazards1. Due to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their complexity and scope, certain resident risk factors and environmental; hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:a. Bed Safety;c. Falls;f. Poison Control;g. Electrical Safety. During a review of the facility-provided GreenIsland Hand Sanitizer, revised 1/2026, the Information indicated Warnings:For external use only.Flammable, keep away from heat and flame.Avoid contact with eyes or mouth.If irritation or redness & swelling occurs, discontinue use immediately.Do not use if you are allergic to alcohol.Keep out of reach of children. 5). During a review of Resident 31's AR, the AR indicated the facility admitted the resident on 5/21/2020, and readmitted the resident on 12/12/2025, with diagnoses including convulsions rapid, uncontrollable shaking and muscle spasms caused by involuntary muscle contractions), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and dementia (a progressive state of decline in mental abilities). During a review of Resident 31's H&P, dated 6/6/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 31's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment. During a concurrent observation and interview on 5/4/2026, at 10:28 a.m., with CNA 4, inside Resident 31's room, Resident 31's headboard was observed tilting forward and wobbly. CNA 4 stated the headboard of Resident 31 should not be tilting forward and wobbly, as it can fall on the resident's head causing injury. CNA 4 stated she will report the issue right away so the maintenance can fix or replace the bed. During a concurrent interview and record review on 5/6/2026, at 11:28 a.m., with the ADON, Resident 31's MDS, and CP were reviewed. The ADON stated the headboard of Resident 31 should not be loose and wobbly as it can fall on the resident's head causing injury. The DON stated all staff were responsible to detect hazards on the resident's environment and to report to appropriate departments to fix the issue. During an interview on 5/7/2026, at 2;20 p.m., with the DON, the DON stated the headboard of Resident 31 should have been fixed and replaced as soon as possible. The DON stated the headboard could bump on the resident's head are fall on the resident and cause injury such as trauma to the resident. The DON stated the staff were mandated to report all issues regarding environmental hazards to appropriate departments. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/28/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.Policy Interpretation and ImplementationFacility-Oriented Approach to Safety4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents.Individualized, Resident-Centered Approach to Safety5. Monitoring the effectiveness of interventions shall include the following:a. Ensuring that interventions are implemented correctly and consistently;b. Evaluating the effectiveness of interventions;c. Modifying or replacing interventions as needed; and d. Evaluating the effectiveness of new or revised interventions.Resident Risks and Environmental Hazards1. Due to (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their complexity and scope, certain resident risk factors and environmental; hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:a. Bed Safety;c. Falls;f. Poison Control;g. Electrical Safety. 6). During an observation and interview on 5/7/2026 at 10:47 a.m. with Housekeeping Staff (HS) 2, in the hallway of the facility, Station A's EVS cart compartment holding chemicals was left unlocked and unattended in the hallway. HS 2 stated that the compartment with chemicals were left unlocked and unattended. HS 2 stated that this was an unsafe practice. HS 2 added that leaving the chemical compartment door unlocked could allow residents to access the drawer and obtain chemicals, which may lead to accidental ingestion, exposure or skin injury. During an observation and interview on 5/7/2026 at 10:53 a.m. with HS 3 and Maintenance Supervisor (MS), in the hallway of the facility, Station B's EVS cart compartment holding chemicals was left unlocked and unattended in the hallway. HS 3 and MS stated that it was an unsafe practice to leave the chemical compartment door unlocked and unattended. HS 3 stated that not locking the chemical compartment door could potentially lead to residents accessing the chemicals, consuming or exposing their skin to the chemicals, causing intoxication, burns, and harm the residents. During an interview on 5/7/2025 at 2:00 p.m. with Assistant Director of Nursing (ADON), the ADON stated that leaving chemical compartments unlocked and unattended can result in unauthorized resident access, which may lead to accidental ingestion, exposure to hazardous substances, skin or eye injuries, and potential serious harm, especially for residents with cognitive impairment. 7). During a review of Resident 113's admission Record (AR), the AR indicated the facility originally admitted the resident on 2/10/2020 and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease, unspecified (COPD- a chronic lung disease causing difficulty in breathing); 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); unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (has memory loss, problems with thinking or daily functioning, but the exact type and severity are unknown, and the person is not showing behaviors such as aggression, severe mood changes, and anxiety). During a review of Resident 113's Minimum Data Set (MDS, a resident assessment tool), dated 4/26/2026, the MDS indicated the resident had the ability to make self-understood and had intact cognitive function (normal thinking). The MDS indicated the resident was dependent to supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 113's History and Physical (H&P), dated 4/27/2026, the H&P indicated the resident has mental capacity, and was alert and oriented to person, place, time, and situation. During a concurrent observation and interview on 5/6/2026, at 11:42 a.m., with Certified Nursing Assistant (CNA) 6 and Licensed Vocational Nurse (LVN) 2, inside Resident 113's room, CNA 6 observed an open package of A &D ointment on the nightstand next to Resident 113's bed. CNA 6 grabbed the package and showed it to LVN 2, who was walking into the resident's room. LVN 2 stated it was an A&D ointment package, and it is not supposed to be at Resident 113's bedside because if resident is not alert can accidentally ingest it or someone else can take medication and use it for something else. LVN 2 stated that to self-administer medication there needs to be a care plan, and an assessment if resident can self-administer medication. (continued on next page)

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	055287	A. Building B. Wing	05/08/2026

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview and record review, for Resident 113, on 5/6/2026, at 12:00 p.m., with Licensed Vocational Nurse (LVN) 2, the physician's orders, care plan and assessment to self-medicate, was unable to be located by LVN 2. LVN 2 stated there were no physician orders to self-medicate, no care plan to self-medicate and an assessment to self-medicate was not done.During an interview on 5/7/2026, at 3:11 p.m., with the Director of Nursing (DON), the DON stated that for a resident to self-medicate there needs to be a physician's order, self-medicate assessment, and care plan. The DON stated if the resident does not have a self-medication assessment done, then they would not know if resident was capable of self-administering medications. The DON stated that if medication is left unattended at a resident's bedside there is a risk that someone else can get to it. During a review of the facility's po

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure the safe and appropriate use of bed rails (BR - adjustable, rigid, plastic or metal bars attached to the bed that may be positioned in various locations on the bed; upper or lower, either or both sides) for three of eight sampled residents (Resident 1 7 and 29) reviewed under the Accidents care area.1. For Resident 1 the facility failed to:a. Follow the physician's order to apply grab bars (sturdy, removable metal handles that attach to a bed frame or slide under the mattress). However, the facility applied one-half length bed side rails (one-half-length bed rail is a safety barrier that covers half of a bed, typically near the user's torso). (Side rails are used to prevent patients from falling out of the bed, and a grab bar can help them to pull themselves upright on the bed).b. Perform a one-half length bedside rails assessment.c. Develop a care plan for use of one-half bedrails. 2. For Resident 7 the facility failed to:a. Follow the physician's order to apply a one-quarter-length bed rail (BR) (quarter-length BR is a safety barrier that covers quarter of a bed, typically near the user's head and can be used as a head assist, head rail, or foot rail. This rail provides minimal rail coverage and gives assistance when entering or exiting the bed.b. Obtain accurate informed consent for bed rail use. 3. For Resident 29 the facility failed to:a. Develop a care plan for use of half-length bilateral bed rails.b. Obtain accurate informed consent for half-length bilateral bed rails.c. Perform a Half Bed Rail assessment.These deficient practices placed the residents at risk for potential accidents such as a body part being caught between the rails, and falls if a resident attempts to climb over, around, between, or through the rails.Findings: 1. During a review of Resident 1's admission Records ([AR] - the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility admitted Resident 1 on 4/14/2026, with diagnoses including acute respiratory failure with hypoxia (a sudden, life-threatening emergency where the lungs cannot get enough oxygen into the bloodstream to support the body's organs), sepsis (a life-threatening blood infection), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set ([MDS] - a resident assessment tool) dated 4/18/2026, the MDS indicated Resident 1 had a BIMS ([Brief Interview for Mental Status] - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 3 (BIMS score 3 indicates severe cognitive impairment - the person likely has significant trouble with memory, orientation (knowing the date/time), and thinking skills, suggesting a high need for support). The MDS indicated that Resident 1 was dependent (helper does all of the effort) with oral, toileting and personal hygiene, upper and lower body dressing, putting on/taking off footwear. During a concurrent observation and interview on 5/4/2026 at 9:20 a.m. with Certified Nurse Assistant (CNA) 8, in Resident 1's room, CNA 8 was observed providing care to Resident 1 while the resident was lying in bed with elevated bilateral half-length bed rails. CNA 8 stated that Resident 1's bilateral BRs were always kept elevated to prevent Resident 1 from falling. During a concurrent interview and record review on 5/7/2026 at 12:11 p.m. with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 1's electronic medical records (EMR), including the following: a. Order Summary Report (OSR - a report reflecting all current active physician orders for the resident's care). The ADON stated that the OSR included a physician order dated 4/15/2026 for the use of bilateral grab bars to assist with turning and repositioning and as an (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	enabler. The ADON further stated that grab bars and one-half bed rails (1/2 BR) were not the same equipment. The ADON explained that when grab bars are pulled down, they function as one-half bed rails (1/2 BR). b. Side Rail Utilization assessment dated [DATE]. The ADON stated that the assessment was completed for bilateral grab bars, and not for one-half bed rails.c. CP initiated and revised on 4/16/2026. The ADON stated the care plan was developed for grab bars only. The ADON further stated there was no care plan documentation addressing the use of one-half bed rails (1/2 BR). The ADON stated that these failures had the potential to result in the unsafe use of inappropriate equipment and increased the resident's risk for injury, including entrapment. 2. During a review of Resident 7's AR, the AR indicated that the facility admitted Resident 1 on 9/12/2025, with diagnoses including metabolic encephalopathy (a temporary brain malfunction caused by chemical imbalances in the body rather than a direct head injury), type II diabetes mellitus, end stage renal disease (ESRD - irreversible kidney failure). During a review of Resident 7's History and Physical (H&P), dated 9/14/2025, the H&P indicated that the resident had the capacity to understand and make a decision. During a review of Resident 7's MDS, dated [DATE], the MDS indicated that Resident 7 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing. During a concurrent observation and interview on 5/4/2026 at 12:32 p.m. with CNA 9, in Resident 7's room, it was observed that Resident 7 was lying in bed with bilateral one-half bed rails elevated. CNA 7 stated that Resident 7 was afraid of falling and requested to have the bilateral bedrails elevated when in bed. During a concurrent interview and record review on 5/7/2026 at 1:46 p.m. with ADON, the ADON reviewed Resident 7's electronic medical records (EMR), including: a. OSR. The ADON stated the OSR indicated a physician order for quarter bed rails (1/4 BR) use on both sides of the bed for turning and repositioning, dated 11/9/2025. The ADON stated that one-quarter (1/4 BR) was half of the one-half (1/2 BR). b. Informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for Physical Restraint and Side Rails, dated 11/10/2025. The ADON stated that the informed consent did not indicate Resident 7's or the resident representative's signatures. The ADON stated that these failures could potentially cause unsafe use of inappropriate equipment and increase risk of the resident's injury, including entrapment. 3. During A review of Resident 29's AR, the AR indicated the facility originally admitted the resident on 1/17/2019 and readmitted on [DATE], with diagnoses including muscle weakness (Generalized) (weakness in many muscles throughout the body); unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety (has memory loss, problems with thinking or daily functioning, but the exact type and severity are unknown, and the person is not showing behaviors such as aggression, severe mood changes, and anxiety); acquired absence of right leg above knee (the surgical removal of the leg above the knee joint). During a review of Resident 29's H&P, dated 11/18/2025, the H&Pˆindicatedˆthe resident has the capacity to make decisions. During a review of Resident 29's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognitive function (normal (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	thinking). The MDS indicated the resident required dependent to supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 29's OSR, dated 4/11/2026, the OSR indicated an order that Resident 29 may use one-half side rails on both sides of the bed for turning and repositioning. ˆ During a review of Resident 29's Consent-Facility Verification of Informed Consent for Physical Restraint and Side rails, dated 4/11/2026, the consent indicated for the use of one-quarter side rail on both sides of the bed. ˆDuring a review of Resident 29's Side Rail Utilization Assessment (SRUA), dated 4/11/2026, the SRUA indicated that they may use quarter length side rails on both sides of the bed for turning and repositioning. During a review of Resident 29's CP Report titled, Resident use quarter length (1/4 SR) on both sides of the bed for turning and repositioning, dated 4/11/2026, the CP indicated an intervention to keep the bed in the lowest position when not actively repositioning the resident. During a concurrent observation and interview on 5/4/2026, at 12:44 p.m., withˆCNA 7, in Resident 29's room, Resident 29's bed was observed with a rail on the right middle side of the bed and CNA 7 stated CNA 7 does not know the size of the bed rail, if it was a quarter length(1/4) or one-half length (1/2) and on the left upper side of the bed another rail and CNA 7 stated that rail was a grab bar. During a concurrent interview and record review for Resident 29 on 5/7/2026, at 3:00 p.m., with the ADON, the OSR, CP, consent for side rails, and SRUA was reviewed. The ADON stated the CP is for the quarter length rails and not one-half length side rails and the CP is incorrect and does not match the OSR dated 4/11/26. The ADON stated the consent for side rails dated 4/11/2026 was for one-quarter side rails and not for one-half length side rails which is not accurate. The ADON stated that the SRUA dated 4/11/2026 was for the one-quarter not the one-half side rails so it is not accurate. ˆThe ADON stated the side rail consent, SRUA, and CP needs to match the OSR and for Resident 29 none matched the OSR. During a review of facility's Policies and Procedures (P&P), titled Bed Safety and Bed Rails, dated 1/28/2026, the P&P indicated, 1. Bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eight lengths3. The use of bed rails or side rails (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent.8. Before using bed rails for any reason, the staff shall inform the residents or representatives about the benefits and potential hazards associated with bed rails and obtain informed consent.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure that nursing staff did not have a complete performance review for the following: 1. Provide basic activities of daily living (ADLs - toileting hygiene, shower/bathing) care training for one of five sampled staff (Certified Nursing Assistant 1). 2. Provide annual performance evaluation for four of five staff (Registered Nurse [RN] 1, Treatment Nurse [TN] 1, Certified Nursing Assistant [CNA] 1, and Certified Nursing Assistant [CNA] 2). These deficient practices had the potential for lack of knowledge and training among the staff, leading to inadequate resident care. Findings: During a review of the facility assessment tool (used to evaluate a facility's resident population, operational needs, and resource capacity to provide necessary care), revised 08/1/2025, the facility assessment tool indicated that the facility conducts an audit of all direct care staff competencies before the end of 2025. Additionally, competency training for staff continues to be an annual standard of practice within the facility. During a concurrent interview and record review on 5/8/2026 at 7:23 a.m. with the Director of Staff Development (DSD), five employee personal files were reviewed. A. CNA 1 employee records indicated that ADL care training was last completed on 10/31/2024. The DSD stated that CNA 1 also assists the nursing staff so they should have ADL care training. B. The DSD stated that performance evaluations are conducted annually or whenever retraining is necessary. The DSD stated that the Director of Nursing (DON) or Assistant Director of Nursing (ADON) oversees the evaluations of performance of the licensed nursing staff, while the DSD ensures they are completed. The DSD stated that RN 1 had her last annual performance review on 11/18/2024 with uncompleted for 2025 or 2026. The DSD stated that TN 1's last annual performance review was completed on 11/11/2024 and none for year 2025 and 2026. The DSD stated that CNA 1 did not receive an annual performance evaluation, and CNA 2 had his last performance review on 1/16/2025, with none for 2026. During a continued interview and record review on 5/8/2026 at 7:23 a.m. with the DSD, the DSD stated that she did not have an established process to track which staff members are due for evaluations and acknowledge the need for improvements in tracking to ensure continuity. The DSD stated that performance evaluations are crucial for retraining, reinforcing knowledge and skills, improving performance, and preventing errors among staff. During an interview on 5/8/2026 at 10:00 a.m. with the DON, the DON stated that she conducts annual performance evaluations for licensed nursing staff. The DON stated that the DSD handles performance evaluation for certified nursing staff. The DON stated that performance evaluations are intended to discuss staff performance and expectations, provide feedback, set individual goals, and offer recommendations for training and improvement. The DON stated that if staff are unaware of their performance or fail to meet goals and expectations, it can impact on resident care and hinder the ability to ensure residents' health and safety. During a review of the facility's policy and procedures (P&P) titled, Performance Evaluation, reviewed 1/28/2026, the P&P indicated the performance evaluation will be conducted for each employee at the conclusion of their 90-day probationary period, and at least annually thereafter. Performance evaluations are completed by department directors and supervisors and reviewed by the director of human resources. The final performance evaluation is sent by the director or supervisor to the director of human resources to be filed in the employee's personnel record. During a review of facility's P&P titled, Staffing, Sufficient and Competent Nursing, reviewed 1/28/2026, the P&P indicated that licensed nurses and nursing assistants are required to be trained and must prove their competence in recognizing, documenting, and reporting changes in residents' conditions according to their scope of practice and assigned duties.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of two sampled residents (Residents 76 and 39) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F658. Findings: 1. During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted the resident on 6/9/2023, and readmitted the resident on 8/4/2025, with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), adult failure to thrive (a rapid or severe decline in an older person's physical and mental health that cannot be blamed on one specific disease), and dysphagia (difficulty swallowing). During a review of Resident 76's History and Physical (H&P), dated 8/5/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 2/20/2026, the MDS indicated the resident usually had the ability to make self-understood and usually had the ability to understand others and had severe cognitive impairment (a serious decline in mental ability-such as memory, reasoning, and communication-that makes a person unable to live independently, manage daily tasks, or care for themselves safely). The MDS indicated that the resident was on a high-risk drug class hypoglycemic medication (prescription pills or medications designed for people with Type 2 diabetes to help lower high blood sugar levels). During a review of Resident 76's Order Summary Report (OSR), dated 12/6/2025, the OSR indicated an order for Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 unit per milliliters (unit/ml, how many units of medication are packed into 1 mL of liquid) (Insulin Aspart). Inject as per sliding scale (a personalized chart that tells a person with diabetes how much insulin to take based on their blood sugar level at that specific moment): if 70 - 149 = 0 UNIT If blood sugar (BS) is less than (<) 70 give orange juice (OJ) if awake and able to swallow then notify MD; 150 - 199 = 1 UNIT; 200 - 249 = 2 UNITS; 250 - 299 = 3 UNITS; 300 - 349 = 4 units >349=5 UNITS then call MD, subcutaneously four times a day for DM2 Rotate injection sites. During a review of Resident 76's Location of Administration Report (LAR) for Insulin for 4/2026, the LAR indicated that insulin was subcutaneously given on: Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 unit/ml 4/1/2026 at 7:06 a.m. on the Abdomen - Left Upper Quadrant (LUQ) 4/2/2026 at 7:10 a.m. on the Abdomen - LUQ 4/15/2026 at 9:53 p.m. on the Abdomen - LUQ 4/16/2026 at 4:46 p.m. on the Abdomen - LUQ 4/24/2026 at 7:09 a.m. on the Abdomen - Right Upper Quadrat (RUQ) 4/24/2026 at 4:46 p.m. on the Abdomen - RUQ During a review of Resident 76's Care Plan (CP) Report titled, The resident has Diabetes Mellitus, last revised on, the CP indicated an intervention to rotate injection sites. During a concurrent interview and record review on 5/6/2026 at 11:44 a.m. with the Assistant Director of Nursing (ADON), Resident 76's OSR, LAR, and CP were reviewed. The ADON stated there was an order from the physician to rotate sites of administration of the insulin, the LAR for 4/2026 had repeated administration sites. The ADON stated the policy and procedure (P&P) titled, Insulin Administration, was not followed. The ADON stated that they were rotating sites of administration to prevent lipodystrophy on residents. The DON added administering medications to sites of lipodystrophy may affect the absorption of the insulin and may cause hypo/hyperglycemia to (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. The ADON stated not rotating insulin administration site was considered as a medication error. During an interview on 5/7/2026 at 2:20 p.m. with the DON, the DON stated the sites of administration of insulin for Resident 76 should be rotated to avoid infection and trauma to the site. The DON stated frequently administering insulin on the same site hardens the skin of the area which causes lipodystrophy. The DON stated that administering insulin on the site of lipodystrophy will have impaired absorption. The DON stated the resident can suffer from hypo/hyperglycemia. The DON stated that not rotating insulin administration sites as a form of medication error. 2. During a review of Resident 39's AR, the AR indicated the facility admitted the resident on 8/22/2016, and readmitted the resident on 2/17/2025, with diagnoses including type 2 diabetes mellitus, morbid obesity (a chronic disease defined as being 100 pounds or more over ideal body weight, or having a BMI of 40 or higher), and dysphagia. During a review of Resident 39's H&P, dated 2/18/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 39's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities-such as memory, thinking, reasoning, and judgment-are working normally and without significant impairment or decline). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 39's Order Summary Report (OSR), the OSR indicated an order for: 2/17/2025 Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 unit/ml (Insulin Aspart). Inject as per sliding scale: if 200 - 250 = 2 units if BS is < 70 Give OJ if awake and able to swallow then notify MD; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units; 401 - 450 = 10 units; 451 - 500 = 12 units >500 CALL MD, subcutaneously before meals and at bedtime for DM Rotate injection sites. 2/18/2025 Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 30 unit subcutaneously two times a day for DM **Rotate injection site; Hold if BS is < 100, notify MD if BS is < 60 or greater than (>) 400. During a review of Resident 39's Care Plan (CP) Report titled, Resident is at risk for hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) related to Diabetes Mellitus, initiated on 6/20/2018, the CP indicated an intervention to rotate the injection site. During a review of Resident 39's LAR of Insulin for 4/2026, the LAR indicated that insulin was subcutaneously given on: Insulin Glargine Subcutaneous Solution Pen injector 100 unit/ml 4/14/2026 at 8:02 a.m. on the Abdomen - LUQ 4/15/2026 at 5:20 p.m. on the Abdomen - LUQ 4/27/2026 at 8:06 a.m. on the Abdomen - Right Lower Quadrant (RLQ) 4/27/2026 st 6:55 p.m. on the Abdomen - RLQ Insulin Aspart Pen Fill Subcutaneous Solution Cartridge 100 unit/ml 4/4/2026 at 12:59 p.m. on the Abdomen - RLQ 4/4/2026 at 10:19 p.m. on the Abdomen - RLQ During a concurrent interview and record review on 5/6/2026 at 11:44 a.m. with the ADON, Resident 39's OSR, LAR, and CP were reviewed. The ADON stated there was an order from the physician to rotate sites of administration of the insulin, the LAR for 4/2026 had repeated administration sites. The ADON stated the P&P titled Insulin Administration, was not followed. The ADON stated that they were rotating sites of administration to prevent lipodystrophy on residents. The DON added administering medications to sites of lipodystrophy may affect the absorption of the insulin and may cause hypo/hyperglycemia to residents. The ADON stated not rotating insulin administration site was considered as a medication error. During an interview on 5/7/2026 at 2:20 p.m. with the DON, the DON stated the sites of administration of insulin for Resident 39 should be rotated to avoid infection and trauma to the site. The DON stated frequently administering insulin on the same site hardens the skin of the area which causes lipodystrophy. The DON stated that administering insulin on the site of lipodystrophy will have impaired absorption. The DON stated the resident can suffer from hypo/hyperglycemia. The DON stated that not rotating insulin administration sites is a form of medication error. During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed on 1/28/2026, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Medication Errors 1. A medication error is defined as the preparation or administration (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of drugs or biological which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services.^ During a review of the facility's recent P&P titled, Insulin Administration, last reviewed 1/28/2026, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16. Select an injection site. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility provided A Step-by-Step Guide to Using Your Lantus SoloStar Pen, copyright 2022, the Guide indicated to change (rotate) your injection sites within the area you chose with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Do not use the same spot for each injection or inject where the skin is pitted, thickened, lumpy, tender, bruised, scaly, hard, scarred or damaged. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Insulin Aspart injection, for subcutaneous or intravenous use, with initial U.S. approval on 2000, the HPI indicated to rotate injections sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis.^

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe provisions of pharmaceuticals services by failing to remove two expired medications from medication carts and mark six medications with an open date in two of four medication carts (Station A Middle medication cart and Station B medication cart). These deficient practices had the potential to result in administration of expired medications, reduced therapeutic effectiveness and compromised resident safety and medication errors. Findings: During a concurrent observation and interview with Licensed Vocational Nurse (LVN) 2 on 5/6/2026 at 10:35 a.m. of Station A Middle medication cart the following was observed: - Novolog Flexpen SYG (a pre-filled, disposable insulin pen used to manage blood sugar in adults and children with diabetes) 5X3ml was not labeled with an open date. - Lantus Solostar (a pre-filled pen containing long-acting insulin (insulin glargine) used to treat Type 1 and Type 2 diabetes by lowering high blood sugar) 100U/ml was not labeled with an open date. - Clonazepam (a prescription medication used to calm the brain and nervous system) 0.5 milligram (mg - a unit of measure for weight) bubble pack, prescribed and filled on 1/30/2026 for 14 days use was not removed from the medication cart. - A tube of Anecream (over the counter, fast-acting numbing cream) 5% was not labeled with an open date. - A tube of triamcinolone (a prescription-strength, medium-to-strong steroid [corticosteroid] used to treat inflammation) 0.1% was not labeled with an open date. - Two tubes of diclofenac sodium (a strong, prescription-strength anti-inflammatory medication) 1% topical gel were not labeled with an open date. LVN 2 stated that a Novolog Flexpen, a Lantus Solostar, a tube of Anecream, a tube of triamcinolone and two tubes of diclofenac sodium were not labeled with an open date. LVN 2 stated that not labeling medications with open dates may result in use beyond recommended timeframes, potentially leading to reduced efficacy. LVN 2 stated for insulin, this could affect blood glucose control and compromise residents' safety. LVN 2 stated that clonazepam bubble pack remained in the medication cart beyond the expected completion date. LVN 2 stated that not removing expired or discontinued medications from medication cart could create a risk for unintended administration with decreased effectiveness or potential harm to residents. During a concurrent observation and interview on 5/6/2026 at 11:10 a.m. with LVN 3 of Station B medication cart, a metoprolol tartrate (a prescription beta-blocker medication that treats high blood pressure, chest pain [angina], and protects the heart after a heart attack) 25 mg bubble pack was in the medication cart and had an expiration date of 1/30/2026. LVN 3 stated that she believed it was a label printer issue. LVN 3 stated the label on the bubble pack indicated expiration date of 1/30/2026. During a concurrent observation and interview on 5/6/2026 at 11:18 a.m. with the Director of Nurses (DON) at the nurses station B, by Station B medication cart, the DON was observing the label on the metoprolol tartrate 25 mg bubble pack. The DON stated that the label indicated expiration date of 1/30/2026. The DON stated medications with expired or questionable expiration dates must be removed from the medication cart immediately. The DON stated questionable labels must be verified and reconciled with the pharmacist. The DON further stated that administering medications with an unknown or expired date was an unsafe practice, increasing the risk of medication errors and may result in reduced effectiveness or potential harm to residents. During an interview on 5/6/2026 at 2:30 p.m. with the DON, the DON stated that insulin pens and topical medication tubes must be labeled with a date upon opening. The DON stated that not labeling medications with an open date may lead to use beyond the recommended timeframes, resulting in reduced efficacy and potential harm to the residents. During a review of facility's policies and procedures (P&P) titled, Medication Labeling and Storage, dated 1/28/2026, the P&P indicated, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Multi-dose vials (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. If medication containers have missing, incomplete, improper or incorrect labels, contact the dispensing pharmacy for instructions regarding returning or destroying these items.

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs when staff did not follow the portion size of grilled bratwurst, three (3) ounces (oz, unit of measurement), and served 1.5 oz portion size instead. This failure had the potential to result in decrease in food flavor, decrease in food and nutrient intake affecting 20 of 91 residents who are on regular diet, potentially resulting in unplanned weight loss. Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Spring 2026, dated 5/4/2026, the spreadsheet indicated residents on regular diet would include the following foods on the tray: - Grilled Bratwurst (3) ounces (oz, a unit of measurement) - Buttered new potatoes 1/2 cup (c, a household measurement) - Sauerkraut 1/2 c - Wheat roll 1 pc - Margarine 1 pc - Oatmeal raisin cookie 1 each - Water 8 fluid oz During an observation on 5/4/2026 at 11:12 a.m. of the food preparation, observed the Dietary Supervisor (DS) cutting the grilled bratwurst into half on a yellow chopping board. During a concurrent observation and interview on 5/4/2026 at 12:26 of the bratwurst portion sizes with the Registered Dietitian (RD) and the DS, observed half portion of bratwurst plated on residents' plates. The DS stated the portion size of the bratwurst is one half (1/2) portion because the recipe calls for it to be cut in half. Observed the DS weighed random portion size of the bratwurst and the facility scales read: - 1st portion: 1.5 oz - 2nd portion: 1.5 oz The RD stated if the bratwurst was under the portion size it placed the residents at risk for weight loss. During a review of the facility's policies and procedures titled, Menus, dated 1/28/2026, the P&P indicated, Menus are developed to meet resident choices including religious, cultural, and ethnic needs while following established national guidelines for nutritional adequacy. (1) Menus meet the nutritional needs of the residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences). Menus provide a variety of foods from basic daily food groups and indicate standard portions at each meal. During a review of the facility's P&P titled, Kitchen Weights and Measures, dated 1/28/2026, the P&P indicated, Food service staff will be trained in proper use of cooking and serving measurement to maintain portion control. Cooks and food service staff will be trained in weights and measures, volume and weights, appropriate utensils use, and food can sizes. During a review of the facility's P&P titled, Standardized Recipes, dated 1/28/2026, the P&P indicated, Standardized recipes shall be developed and used in the preparation of foods. During a review of the facility's recipe titled, Grilled Bratwurst (Pork Chop), dated 1/28/2026, the P&P indicated, suggested portion size 3 oz.3. Cut all portions of bratwurst in half, lengthwise. Serve 3 oz per portion.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperature when hot foods were not served hot. This failure had the potential to result in 88 of 91 facility residents including Resident 53 at risk of unplanned weight loss, a consequence of poor food intake. Findings: During a review of Resident 53's admission Record (AR), the AR indicated the facility admitted Resident 53 on 4/15/2026 with diagnoses including, but not limited to, essential hypertension (HTN, high blood pressure), chronic respiratory failure (a sudden inability of the lungs to transfer enough oxygen into the blood, resulting in low blood oxygen levels), and acute kidney failure (the sudden and often reversible loss of the kidney's ability to filter waste products from the blood, occurring within hours or days). During a review of Resident 53's Minimum Data Sheet (MDS- a resident assessment tool), dated 4/20/2026, the MDS indicated Resident 53 understood others and make self understood. The MDS indicated Resident 53 needed set-up and clean-up assistance (helper sets up or cleans up; residents complete the activity. Helper assists only prior to or following the activity) when eating. During a review of Resident 53's Order Recap Report, dated 4/15/2026, the report indicated Resident 53 was ordered low fat, low cholesterol (avoid foods such as whole milk, cream, fatty meats and fried foods), no added salt (NAS, no salt packet on the tray), regular texture, thin consistency, and 1500 ml fluid restriction. During an interview on 5/4/2026 at 3 p.m. with Resident 53, Resident 53 stated the facility needs a hot box to keep food warm because this place does not keep their food warm and it would make a difference to receive the food warm. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Spring 2026, dated 5/4/2026, the spreadsheet indicated residents on regular diet would include the following foods on the tray: - Grilled Bratwurst (3) ounces (oz, a unit of measurement) - Buttered new potatoes 1/2 cup (c, a household measurement) - Sauerkraut 1/2 c - Wheat roll 1 pc - Margarine 1 pc - Oatmeal raisin cookie 1 each - Water 8 fluid oz During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 5/4/2026 at 1:26 p.m. of the regular diet, observed the Dietary Supervisor (DS) took the temperature of the following using the facility thermometer. The DS stated the thermometer read the following temperature of the foods: - Grilled Bratwurst 80 degrees Fahrenheit (F, a degree of temperature) - Buttered new potatoes 90 F - Sauerkraut 82 F During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Spring 2026, dated 5/4/2026, the spreadsheet indicated residents on soft bite diet (food that are bite sized pieces no more than 1.5 centimeters (cm., a unit of measurement) to 1.5 cm., soft, tender and moist food but with no liquid leaking or dripping from the food) would include the following foods on the tray: - Soft bite grilled bratwurst with gravy 3 oz/1 oz - Soft bite buttered new potatoes 1/2 c - Soft bite sauerkraut 1/2 c - Puree bread 1 each - Margarine 1 each - Puree sugar cookie 1/4 c During a concurrent test tray observation and interview on 5/4/2026 at 1:26 p.m. of the soft bite size diet, observed the DS took the temperature of the following using the facility thermometer. The DS stated the thermometer read the following temperature of the foods: - Minced and moist pork chop 83 F - Soft bite sized new potatoes 80 F - Soft bite sized sauerkraut 82 F During an interview on 5/4/2026 at 1:30 p.m. with the DS, the DS stated the food temperatures were not good because of the delay in trayline (an area where foods were assembled from the steamtable to resident's plate). The DS stated hot food usually comes out at 110 to 115 F. The DS stated residents could complain of cold food and the time the food could be out would be less than 2 hours. The DS stated residents would not like cold food and would not eat much as a potential outcome. During a review of the facility's policies and procedures (P&P) titled Food and Nutrition Services, dated 1/28/2026, the P&P indicated, Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking in consideration the preferences of each resident.4. Reasonable efforts will be made to accommodate resident choices and preferences. 7. Food and (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident, the food appears palatable and attractive, and it is served at a safe and appetizing temperature.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure residents on soft bite size level 6 diet (food that are bite sized pieces no more than 1.5 centimeters (cm., a unit of measurement) to 1.5 cm., soft, tender and moist food but with no liquid leaking or dripping from the food) received and consumed food in appropriate texture as prescribed by a physician. Residents were served minced and moist diet instead. This deficient practice had the potential to result in ineffective therapeutic diet, decreased in nutrient intake affecting 10 of 91 residents potentially resulting in weight loss. Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Spring 2026, dated 5/4/2026, the spreadsheet indicated residents on soft bite sized diet would include the following foods on the tray: - Soft bite grilled bratwurst with gravy three (3) ounces (oz. a unit of measurement)/1 oz - Soft bite buttered new potatoes 1/2 cup (c., household measurement) - Soft bite sauerkraut 1/2 c - Puree bread 1 each - Margarine 1 each - Puree sugar cookie 1/4 c During an observation on 5/4/2026 at 11:20 a.m., of the food preparation, observed the Dietary Supervisor (DS) chopped the grilled bratwurst. During an observation on 5/4/2026 at 11:22 a.m., of the food preparation, observed the DS performing the fork pressure test (testing method used to assess how the food changes when pressure is applied to food with the tines/prongs of a fork) and told the kitchen staff the bratwurst did not pass the fork pressure test. The DS instructed [NAME] 1 to ground the bratwurst. During a concurrent observation on 5/4/2026 at 11:51 a.m., of the food preparation with the DS, observed the DS performing a fork test on the pork chops. The DS stated the pork chops did not pass the fork test for soft bite size diet because she could not cut it using a fork. The DS stated she was going to blend it to minced and moist texture. During an interview on 5/4/2026 at 12:35 p.m., with the DS, the DS stated the easy-to-chew meats did not pass the fork pressure test and they made it as minced and moist texture instead. During an interview on 5/4/2026 at 12:50 p.m. with the Registered Dietitian (RD), the RD stated serving minced and moist food to soft bite sized diet was okay from a safety perspective so residents could swallow the food with no issues, but the kitchen staff were not following the recipe. The RD stated they were downgrading the diet instead of providing soft bite sized foods. The RD stated the diet was upgraded so that residents would eat more and if the residents would not eat more, there would be a risk of weight loss. During an interview on 5/4/2026 at 1:38 p.m., with the DS, the DS stated the soft bite sized food should pass the fork pressure test however the meat did spring back to its original form. The DS stated the size of the food for the soft bite size should not be bigger than 1.5 cm to 1.5 cm. The DS stated serving minced and moist diet was the safest thing to do but it was not doing diet progression for the residents. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diets, dated 1/28/2026, the P&P indicated, Therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and preferences. 1. Diet will be determined in accordance with the residents' informed choices, preferences, treatment goals and wishes. Diagnosis alone will not determine whether the resident is prescribed a therapeutic diet. 2. A therapeutic diet must be prescribed by the resident's attending physician (or non-physician provider). The attending physician may delegate this task to a registered or licensed dietitian as permitted by stated law. 3. Diet order should match the terminology used by the food and nutrition service department. 4. A therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet, for example a. Diabetic/calorie-controlled diet b. Low sodium diet c. Cardiac diet and d. Altered consistency diet. 5. If a mechanically altered diet is ordered, the provider will specify the texture modification. During a review of the facility's diet manual (DM) titled, Soft and Bite Sized Texture, dated 1/28/2026, the DM indicated, a diet used in the dietary management of (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dysphagia with the food texture to be prepared as soft, tender, and moist with no separate thin liquid.Biting is not required, but chewing is required. The diet does require the resident to have adequate tongue force to move the bolus to prevent aspiration. During a review of the facility's standardized recipe titled, Pork Chop, dated 1/28/2026, the recipe indicated, SB6: chop cooked regular portions. During a review of the IDDSI guideline website titled, IDDSI, dated 7/2019, the IDSSI guideline indicated, Soft and Bite Sized foods are soft, tender and moist but with no thin liquid leaking/dripping from the food. Ability to bite off a piece of food is not required but ability to chew bite-sized pieces so that they are safe to swallow is required. During a review of the IDDSI guideline website titled, IDDSI, dated 7/2019, the IDSSI guideline indicated, Minced and moist foods are soft, moist, but with no thin liquid leaking/dripping from the food. Biting is not required and minimal chewing is required.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the electrical and patient care equipment in safe operating condition for four of nine sampled residents (Residents 76, 31, 2,15, and 49) reviewed under environmental task by failing to ensure there were no frayed wires on the resident's bed remote controls.^ The deficient practice had the potential for residents to sustain accidents such as electrical shock and physical discomfort. Findings: 1). During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted the resident on 6/9/2023, and readmitted the resident on 8/4/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), disorientation, and adult failure to thrive (is a, usually in older adults, defined by a rapid, overall decline in physical and mental health). During a review of Resident 76's History and Physical (H&P), dated 8/5/2025, the H&P indicated the resident did not have a capacity to make decisions. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated the resident usually had the ability to make self-understood and understand others and had severe cognitive impairment (a profound loss of mental capacity where a person can no longer live independently, manage daily tasks (like bathing or dressing), or safely care for themselves). During a review of Resident 76's Care Plan (CP) Report titled, The resident is at risk for falls related to diagnosis of Parkinsons (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) ., last revised on 8/5/2025, the CP indicated an intervention of the resident needs a safe environment. During a concurrent observation and interview on 5/4/2026, at 10:19 a.m., with Licensed Vocational Nurse (LVN) 3, inside Resident 76's room, Resident 76's bed remote control was observed with frayed wires near the control pad. LVN 3 stated there should be no frayed wires on the remote control for the bed, as it can cause electric shock. During a concurrent interview and record review on 5/6/2026, at 2:44 p.m., with the Assistant Director of Nursing (ADON), Resident 76's MDS and CP was reviewed. The ADON stated there should be no frayed wires on the remote control because it can cause electrical shock. The ADON stated the facility did not follow the care plan regarding the resident being at risk for falls to provide a safe environment. During an interview on 5/7/2026, at 2:20 p.m., with the Director of Nursing (DON), the DON stated there should be no frayed wires on the bed remote control of Resident 76 because it can cause potential harm such as electrocution. The DON stated the maintenance department is responsible, but the staff should report as well. 2). During a review of Resident 31's AR, the AR indicated the facility admitted the resident on 5/21/2020, and readmitted the resident on 12/12/2025, with diagnoses including paroxysmal atrial fibrillation (an irregular, often rapid heart rhythm that comes and goes, starting and stopping on its own within seven days), dementia, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 31's CP Report regarding the resident being at risk for falls, related to a history of falls, afib (a common heart condition where the heart's upper chambers (atria) beat irregularly and very fast, rather than contracting effectively) ., last revised on 5/1/2025, the CP indicated an intervention indicating the resident needs a safe environment. During a review of Resident 31's H&P, dated 6/6/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 31's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in memory, thinking, or reasoning skills that interferes with daily life, but is not as severe as dementia). (continued on next page)

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Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/4/2026, at 10:39 a.m., with Certified Nursing Assistant (CNA) 4, inside Resident 31's room, Resident 31's bed remote control was observed with frayed wires near the control pad. CNA 4 stated there should be no frayed wires on the bed remote control as it can cause electric shock. During a concurrent interview and record review on 5/6/2026, at 2:44 p.m., with the ADON, Resident 31's MDS and CP were reviewed. The ADON stated there should be no frayed wires on the bed remote control of the resident because it can cause electrical shock. The ADON stated the facility did not follow the care plan regarding the resident at risk for falls to provide a safe environment. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated there should be no frayed wires on the bed remote control of Resident 31 because it can cause potential harm such as electrocution. The DON stated the maintenance department is responsible, but the staff should report as well. 3). During a review of Resident 2's AR, the AR indicated the facility admitted the resident on 6/30/2022, and readmitted the resident on 3/31/2026, with diagnoses including cognitive communication deficit (a communication problem caused by trouble with thinking skills—such as memory, attention, or reasoning—rather than just a problem with language itself), dementia, and aphasia (a disorder that makes it difficult to speak). During a review of Resident 2's H&P, dated 4/1/2026, the H&P indicated the resident was awake, alert and oriented to person, place, and time. (It is a shorthand term used by healthcare professionals to indicate that a patient is conscious, awake, and mentally aware of their surroundings) and had capacity. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had moderate cognitive impairment. During a concurrent observation and interview on 5/4/2026, at 10:39 a.m., with CNA 4, inside Resident 2's room, Residet 2's bed remote control was observed with frayed wires near the control pad. CNA 4 stated there should be no frayed wires on the bed remote control as it can cause electric shock. During a concurrent interview and record review on 5/6/2026, at 11:11 a.m., with the ADON, Resident 2's MDS and CP were reviewed. The ADON stated there should be no frayed wires on the bed remote control because it can cause electrical shock. The ADON stated the facility did not follow the care plan regarding the resident at risk for falls to provide a safe environment. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated there should be no frayed wires on the bed remote control of Resident 2, because it can cause potential harm such as electrocution. The DON stated the maintenance department is responsible, but the staff should report as well. 4). During a review of Resident 15's AR, the AR indicated the facility admitted the resident on 6/27/2017, and readmitted the resident on 10/15/2018, with diagnoses including dementia, major depressive disorder, and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 15's H&P, dated 10/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 15's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had severe cognitive impairment. During a review of Resident 15's CP Report regarding the resident being dependent on staff for activities, cognitive stimulation., last revised on 2/24/2026, the CP indicated to ensure adaptive equipment the resident needs is provided and is functional. During a concurrent observation and interview on 5/4/2026, at 10:53 a.m., with the Activities Director (AD), inside Resident 15's room, Residet 15's bed remote control was observed with frayed wires near the control pad. The AD stated there should be no frayed wires on the bed remote control as it can cause electric shock. During a concurrent interview and record review on 5/6/2026, at 11:11 a.m., with the ADON, Resident 15's MDS and CP were reviewed. The ADON stated there should be no frayed wires on the bed remote control of the resident because it can cause electrical shock on the resident. The ADON stated the facility did not follow the care plan regarding the resident being at risk for falls to provide a safe environment. During an interview on 5/7/2026, at 2:20 p.m., with the DON, the DON stated there should be no frayed wires on the bed remote control of Resident 15 because it can cause potential harm such as electrocution. The DON (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the maintenance department is responsible, but the staff should report as well. 5). During a review of Resident 49's admission Record (AR), the AR indicated the facility originally admitted the resident on 3/26/2019 and readmitted on [DATE], with diagnoses including hemiplegia, unspecified affecting left nondominant side (weakness or paralysis on the left side of the body); type 2 diabetes mellitus without complications (a disorder characterized by difficulty in blood sugar control and poor wound healing); essential hypertension (high blood pressure with no known specific cause). During a review of Resident 49's History and Physical (H&P), dated 3/6/2026, the H&Pˆindicatedˆthe resident had the ability to understand and make decisions.ˆ ˆ During a review of Resident 49's Minimum Data Set (MDS, a resident assessment tool), dated 3/23/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (has some memory or thinking difficulties but can still communicate and participate in daily activities with some assistance and reminders). The MDS indicated the resident was dependent to supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent observation and interview on 5/4/2026, at 11:37 a.m., withˆLicensed Vocational Nurse (LVN)ˆ3, inside Resident 49's room,ˆResident 49's bed remote control was observed with inner wires exposed. LVN 3 immediately removed the bed control from resident's reach and notified maintenance to repair it. LVN 3 stated the bed remote control should not have any exposed wires because the resident can potentially become electrocuted or injured. During an interview for Resident 49 on 5/6/2026, at 10:34 p.m., with theˆAssistant Director of Nursing (ADON), the ADON stated all staff should detect hazards in resident's environment such as frayed wires on bed remote control and report it to the Maintenance Director. The ADON stated the expectation should be to check the environment for safety every time staff go inside the residents' rooms. The ADON stated staff failed to check the bed remote control for open wires and can be a safety issue and a potential for electric shock. During an interview for Resident 49 on 5/7/2026, at 2:20 p.m., with theˆDirector of Nursing (DON), the DONˆstated there should not be any frayed wires on the bed remote because it can cause potential harm such as electrocution. The maintenance is responsible, but the staff should report as well. During a review of the facility's recent policy and procedure (P&P) titled, Maintenance Service, last reviewed on 1/28/2026, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: b. Maintaining the building in good repair and free from hazards. i. Providing routinely scheduled maintenance service to all areas. 3. The maintenance director is responsible for developing and maintaining a schedule of maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner. ˆ During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/28/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Facility-Oriented Approach to Safety 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, Resident-Centered Approach to Safety 5. Monitoring the effectiveness of interventions shall include the following: a. Ensuring that interventions are implemented correctly and consistently. b. Evaluating the effectiveness of interventions. c. Modifying or replacing interventions as needed; andˆ d. Evaluating the effectiveness of new or revised interventions. Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental; hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed Safety. c. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Falls. f. Poison Control. g. Electrical Safety. During a review of the facility-provided Owner's Operator and Maintenance Manual IVC Bed Series (Full Electric Beds, Semi-Electric Beds, Manual Beds), revised 7/27/20062, the Manual indicated on p. 34 Installing/Removing the Pedant, under Troubleshooting Electrical, bed Hi/Lo movement does not stop. Check cables, if damaged, replace.ˆ Mechanical Inspection and Maintenance -Inspect all bed components for damage or excessive wear. Electrical Inspection and Maintenance -Inspect all electrical bed components for damage or excessive wear (i.e. cracked or broken housings, or worn components). -Check pedant, power and motor cords for chafing, cuts or excessive wear. During a review of the facility's recent P&P titled, Homelike Environment, last reviewed on 1/28/2026, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.

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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, and interview, the facility failed to ensure the call light (an alerting device for residents to call a nursing personnel to assist them when needed)ˆwithin reach of the resident for two of two sampled residents (Residents 10, 88). ˆ The deficient practiceˆhad the potential to place the resident at risk for delayed assistance, potentially affecting safety and timely care.ˆ ˆ Findings: 1. During a review of Resident 10's admission Record, the admission record indicated that Resident 10 was initially admitted to the facility on [DATE] , with diagnoses including hypertension (high blood pressure), history of falling, seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and atrial fibrillation (an irregular and very rapid heart rhythm that and can lead blood clots in the heart). During a review of Resident 10's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ04/19/2026, the MDS indicated that Resident 10's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆseverely impaired. The MDS indicated Residentˆ10ˆrequired extensive physical assistanceˆfrom staffs for activities of daily living (ADLs – toileting hygiene, shower/bathing).ˆˆ During a review of Resident 10's Care Plan Report titled risk for falls revised on 4/23/2026, the care plan intervention indicated to ensure Resident 10's call light is within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 5/04/2026 at 2:28 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 10's call light was observed on the floor. LVN1 stated that the call light should always be within reach, as it allows residents to call for staff assistance. LVN 1 stated it serves as their lifeline when they need help and could face complications when not in reach. During an interview on 5/6/2026 at 2:44 p.m. with Registered Nurse (RN) 1, RN 1 stated that the call light should always be within the resident's reach, as it allows them to request help or communicate their needs. RN 1 explained that when the call light is out of reach, residents may risk falling while trying to access it, and care and needs can be delayed. 2. During a record review of Resident 88's admission Record (AR), indicated the facility admitted the resident on 5/21/2025, with diagnoses including type 2 diabetes mellitus with other specified complication (a disorder characterized by difficulty in blood sugar control and has caused another health problem such as poor wound healing); muscle weakness (Generalized) (weakness in many muscles throughout the body); hypotension, unspecified (low blood pressure, but the exact cause was not identified). During a review of Resident 88's History and Physical (H&P), dated 11/7/2025, the H&Pˆindicatedˆthe resident does not have capacity to make decisions.ˆ During a review of Resident 88's Minimum Data Set (MDS, a resident assessment tool), dated 2/24/2026, the MDS indicated the resident had the ability to usually make self-understood and understand others. The MDS further indicated that Resident 88 had severe cognitive impairmentˆ(has major problems with thinking, memory, understanding, and may need significant assistance with daily activities and supervision for safety). The MDS indicated that the resident needs are dependent to partial/moderate assistanceˆin mobility and activities of daily livingˆ(ADLs,ˆactivities such as bathing, dressing and toileting a person performs daily). During a record review of Resident 88's Quarterly Risk Data Collection Tool (QRDCT), dated 2/24/2026, the QRDCTˆindicatedˆthe resident was at risk for falls.ˆ During a concurrent observation and interview on 5/4/2026, at 10:50 a.m., with Certified Nursing Assistant (CNA) 5 Resident 88's call light was observed on the right side hanging off the bed. CNA 5 stated Resident 88 would not have been able to call for assistance because the call light was out of reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA 5 stated Resident 18 could have fallen trying to reach for the call light and further stated the resident is a fall risk. During a concurrent interview and record review on 5/6/2026, at 2:30 p.m., with Registered Nurse (RN) 1 Resident 88's QRDCT, dated 2/24/2026 was reviewed. RN 1 stated Resident 88 is at risk for falls and should always have a call light within reach. RN1 stated the purpose of the call light is for the residents to call for assistance or help if needed. RN 1 stated Resident 88 would not have been able to call, and Resident 88 could have fallen trying to reach for the call light. RN 1 stated by not having the call light within reach will delay the care and provision of their needs. RN 1 stated the policy Call System, Residents, was not followed. During an interview on 5/7/2026, at 3:11 p.m., with the Director of Nursing (DON) stated that when call light is hanging off the bed Resident 88 could have potentially fallen off the bed trying to reach for call light. During a review of the facility's policy and procedure (P&P) titled, Call System, Residents, last reviewed on 1/28/2026, the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistant from his/her bed, from toileting/bathing facilities and from the floor.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure a copy of the Advanced Healthcare Directive (a legal document indicating resident preference on end-of-life treatment decisions) was uploaded in a resident`s electronic health record to be readily available if needed for one of three sampled residents (Resident 15). The deficient practice violated the resident's rights and/or representative's right to ensure the resident's end-of-life treatment decisions were readily available for staff to honor and implement. Findings: During a review of Resident 15's admission Record (AR), the AR indicated the facility admitted the resident on 6/27/2017, and readmitted the resident on 10/15/2018, with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), cognitive communication deficit (difficulty with speaking, listening, reading, or writing caused by problems with thinking skills rather than just language ability). During a review of Resident 15's History and Physical (H&P), dated 10/15/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 4/17/2026, the H&P indicated the resident usually had the ability to make self-understood and usually had the ability to understand others and had severe cognitive impairment (a profound loss of mental capacity-such as memory, thinking, and reasoning-that makes it impossible for a person to live independently or care for themselves). The MDS indicated that the resident and the family member participated in the assessment and goal setting of care of the resident. During a review of Resident 15's Advance Directive Acknowledgement (ADA), dated 8/25/2019, the ADA indicated the resident had executed an Advance Directive. The Advance Directive cannot be found in Resident 15`s electronic healthcare record. During a review of Resident 15's Care Plan (CP) Report regarding the resident having an advanced directive, last revised on 11/21/2021, the CP indicated the resident with advance directive. The CP also indicated an intervention to offer assistance if resident wishes to execute one or more directive(s). During a concurrent interview and record review on 5/6/2026, at 10:47 a.m., with the Assistant Director of Nursing (ADON), Resident 15's ADA form was reviewed. The ADON stated that the SSD should have followed up the ADA which indicated the resident had executed an advanced healthcare directive. The ADON stated from time to time the advanced healthcare directive changes and they needed to be updated. The ADON stated the purpose of the ADA was to honor the wish of the resident when they cannot decide for themselves. The ADON stated the failure of the SSD to have the Advanced Directive readily retrievable on the electronic healthcare record had the potential for dignity issue because they cannot follow what the resident's wish for life sustaining measures. During a concurrent interview and record review on 5/7/2026, at 9:31 a.m., with the SSD, Resident 15`s Durable Power of Attorney (DPOA, is a legal document that lets you appoint a trusted person (your agent or attorney-in-fact) to handle your financial, legal, or medical affairs if you become unable to do so yourself) and Advance Directive, and Physician Orders for Life-Sustaining Treatment (POLST, a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) were reviewed. The SSD stated that Resident 15`s DPOA indicated that the resident`s son was designated to decide for the resident`s best interest regarding healthcare if she (Resident 15) became incapacitated. The SSD stated that he (SSD) remembered having an interdisciplinary team (IDT, a group of experts from different fields like doctors, nurses, therapists, and social workers who work together closely to create a single, unified care plan for a patient) with the resident `s son regarding Resident 15's advance directive. The SSD stated that he (SSD) called the responsible party (RP) and stated he remembered filling out the Advance Directive Package but cannot remember if it was turned into the facility. The SSD stated he (SSD) will look into old files and will place them on the electronic healthcare record. The SSD stated the copy of Advanced Directive (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one of one sampled resident (Resident 75) had the right to be free from misappropriation (the unauthorized, improper, or unlawful use of funds or other property for purposes other than that for which intended) of the resident's property, when Resident 75's [NAME] stick (a traditional tool used by many Native American tribes to ensure respectful communication during meetings) was missing and the facility failed to: - Update Resident 75's Resident Inventory List (a simple, detailed record of all personal belongings a person brings into an assisted living facility) with [NAME] stick on the resident's possession. - Replace reported lost [NAME] stick promptly. - Keep track of deliveries of the resident`s orders from outside vendors. This failure resulted in Resident 75 experiencing loss of personal property and the potential for misappropriation without timely identification, investigation, and prevention of further occurrences. Findings: During a review of Resident 75's admission Records (AR - the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the AR indicated the facility admitted Resident 75 on 1/09/2020, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) following cerebral infarction (a type ofˆischemic strokeˆwhere a blockage, cuts off blood supply to part of the brain), hypertension (high blood pressure), alcohol abuse. During a review of Resident 75's Minimum Data Set (MDS- a resident assessment tool) dated 3/12/2026, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS indicated Resident 75 was dependent (helper does all of the effort) with toileting hygiene, shower and putting on/taking off footwear. Resident 75 required partial/moderate assistance (helper does less than half the effort) with oral and personal hygiene and upper body dressing. During an interview on 5/4/2026 at 12:36 p.m. with Resident 75, inside Resident 75's room, Resident 75 stated that his [NAME] stick had gone missing approximately one week ago. Resident 75 stated that he (Resident 75) reported the missing item to the Activities Director (AD) on 4/29/2026, however, he (Resident 75) had not received any follow-up or response. During an interview on 5/7/2026 at 10:02 a.m. with AD, the AD stated that on 4/29/2026 Resident 75 had ordered the [NAME] stick through a magazine. The AD stated that Resident 75 notified her of the missing item on 4/29/2026, at which time she (AD) documented the concern in her personal notebook and relayed it to the Social Worker. The AD stated she (AD) did not document the incident in Resident 75's medical records. The AD stated that the item had not been added to Resident 75's Resident Inventory List. The AD added that the facility did not maintain a log for delivered packages or resident-purchased items. The AD stated it was important to log and track items ordered by residents to ensure accurate inventory of personal belongings. The AD further stated that residents may order Over-the-Counter ([OTC] - drugs you can purchase off the shelf at pharmacies, grocery stores, or online without a doctor's prescription) medication or food and beverages from outside vendors, which could pose potential health and safety risks if not monitored by facility staff. During a concurrent interview and record review on 5/7/2026 at 10:25 a.m. with Social Services Assistant (SSA), the SSA stated that the AD reported Resident 75's missing [NAME] stick on 4/29/2026. The SSA stated that facility protocol required immediate initiation of an investigation and completion of a Theft and Loss Investigation Report form (a formal document used to record when company or personal property is stolen, missing, or damaged) upon notification. The SSA added if the item was not located within three to five days, the resident would be reimbursed, or the facility would replace the item. The SSA stated the incident was not documented in Resident 75's medical records. The SSA searched for the Theft and Loss Investigation Report form and stated that was unable to locate the form. During an interview on 5/7/2026 at 1:55 p.m. with Assistant Director of Nursing (ADON), the ADON stated that (continued on next page)

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	055287	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when a resident reports a missing item, facility staff are expected to follow the protocols, including immediate reporting, and initiation of a theft and loss investigation. The ADON added theft and loss incidents must be recorded in residents' medical records. The ADON stated that not following these protocols could negatively impact on resident's psychosocial wellbeing, potentially leading to feeling sad, depressed, and loss of trust in facility staff. During a review of facility's Policies and Procedures (P&P), titled Personal Property, dated 1/28/2026, the P&P indicated, The resident's personal belongings and clothing are inventoried and documented upon admission and updated as necessary. The facility promptly investigates any complaints of misappropriation or mistreatment of residents property.

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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. Based on interview and record review, the facility failed to ensure residents` drug regimen was free from unnecessary drugs for one of two sampled residents (Resident 4) reviewed for psychotropic medication (drugs that change how the brain works to treat mental health conditions) use by failing to ensure: 1. Resident 4's Lorazepam (a prescription medication used for the short-term treatment of severe anxiety, panic attacks, and insomnia)ˆOral Tablet 0.5 milligrams (mg, a unit of weight) had an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). 2. Resident 4's Risperdal (isˆa medication that works in the brain to treat schizophrenia) had the current informed consent. The deficient practices had the potential to result in the use of unnecessary psychotropic drugs for Resident 4 and can lead to side effect/adverse effect (refers to the negative or harmful results that follow from a particular action or event) such as a decline in quality of life and functional capacity. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2025, with diagnoses including psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), anxiety disorder (mental health conditions characterized by persistent, excessive, and uncontrollable fear or worry that interferes with daily life), and auditory hallucinations (the perception of sounds, most commonly voices, that are not actually present in reality). During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/27/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had moderate cognitive impairment (a noticeable decline in memory, thinking, or reasoning skills that interferes with daily life, yet falls short of dementia). The MDS indicated the resident was on a high-risk drug class antipsychotic medication (prescription medications used to treat symptoms of psychosis-such as hallucinations, delusions, and disorganized thinking-by altering brain chemistry, typically by blocking dopamine receptors). During a review of Resident 4's Order Summary Report (OSR), the OSR indicated an order for: 4/7/2026 Risperdal Oral Tablet (Risperidone). Give three (3) mg by mouth at bedtime for psychosis monitor for behavior manifested by (m/b) sudden outburst of anger. 4/17/2026 Lorazepam Oral Tablet 0.5 mg (Lorazepam). Give one (1) tablet by mouth every six (6) hours as needed for anxiety for 30 days m/b verbalizing nervousness. During a review of Resident 4's Informed Consent-Psychoactive Medication (IC), dated 11/14/2025, the IC indicated Risperdal Oral Tablet two (2) mg one (1) tablet by mouth at bedtime for psychosis m/b sudden outburst of anger. During a review of Resident 4's Care Plan (CP) Report titled, Informed Consent- Psychoactive Medication dated 11/14/2025, last revised on 3/21/2026, the CP indicated a black box warning (isˆa serious warning given by the FDA for drugs or drug classes thatˆmay cause serious harm or death.) Risperdal: Increased mortality in elderly patients with dementia-related psychosis. Elderly patients with dementia-related psychosis treated with antipsychotic drugs are at an increased risk of death. Risperidone is not approved for the treatment of patients with dementia-related psychosis. During a review of Resident 4's Care Plan (CP) Report regarding the resident had anxiety manifested by verbalizing nervousness, last reviewed on 3/21/2026, the CP indicated a black box warning Lorazepam: Risks from concomitant use with opioids. Concomitant use of benzodiazepines and opioids may result in profound sedation, respiratory depression, coma, and death. Reserve concomitant prescribing of these drugs for patients for whom alternative treatment options are inadequate. Limit dosages and durations to the minimum required. Follow patients for signs and symptoms of respiratory depression and sedation. Abuse, misuse, and addiction. During a concurrent interview and record review on 5/6/2026, with the Assistant Director of Nursing (ADON), Resident 4's OSR, IC, and CPs were reviewed. The ADON stated there was no informed consent for the use of Lorazepam and the Risperdal consent was from the previous admission. The ADON stated the new (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dosage of the Risperdal was for three (3) mg, the old consent was for two (2) mg. The ADON stated it was important for Lorazepam and Risperdal to have an informed consent to ensure the risks and benefits of taking the medications was explained to the resident and agreed to the treatment plan. The ADON stated that the informed consents honor the right of the resident to informed consent for treatment and the right to accept or decline treatment. During an interview on 5/7/2026, at 2:20 p.m., with the Director of Nursing (DON), the DON stated it was important to have a current informed consents from the resident or representative to ensure the risks and benefits were explained to the resident especially the medications had black box warnings. The DON stated the informed consents honors the right of the resident to agree or disagree with the proposed treatment. During a review of the facility's recent policy and procedure (P&P) titled, Psychotropic Medication Use, last reviewed on 1/28/2026, the P&P indicated residents will not receive medications that are not clinically indicated to treat a specific condition. Resident Evaluations 4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications.ˆ a. The staff and physician will review with the resident/representative the risks related to not taking the medications as well as appropriate alternatives.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to ensure that all alleged violations involving abuse (an action that intentionally causes harm or injures another person), neglect (failing to care for, pay attention to, or do something you are responsible for), exploitation or mistreatment (the act of treating someone unfairly), including injuries of unknown source and misappropriation of resident property (unauthorized, improper, or unlawful use or taking of someone else's assets, funds, or property), are reported immediately, but not later than two (2) hours after the allegation is made for one of thirteen sampled residents (Resident 76) reviewed for accidents by failing to report an injury of unknown origin (a physical injury that was not witnessed by anyone, and cannot be explained by the injured person) when the resident was found on the floor on 12/3/2025 and wasˆnotedˆwithˆtheˆright lateral (side) head bumpˆand abrasion (a superficial wound that occurs when your skin rubs against, presses on, a rough surface), with right lateral great toe skin tear (cut) and was transferred to the hospital. This deficient practice had the potential to result in unidentified abuse in the facility and failure to protect residents from abuse. Findings: During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted the resident on 6/9/2023, and readmitted the resident on 8/4/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), disorientation, and adult failure to thrive (an often elderly, person's rapid, unexpected decline in physical, mental, and social functioning). During a review of Resident 76's History and Physical (H&P), dated 8/5/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had severely impaired vision. The MDS indicated that the resident had severely impaired cognition (a profound, permanent, or progressive loss of mental capacity that prevents a person from living independently and taking care of themselves). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 76's Situation, Background, Assessment, and Recommendation Communication form, (SBAR-a communication tool used by healthcare workers when there is a change of condition among the residents) , dated 12/3/2026, the SBAR form indicated that the resident was seen on the floor next to bed in side lying position on the right side holding bed control. The SBAR form indicated that Resident 76 was confused as baseline, and no changes to level of consciousness (LOC) was noted. The SBAR form further indicated that Resident 76 was observed with a small bump and abrasion to the right-side lateral head and a small skin tear to the right lateral great toe and was transferred to general acute care hospital (GACH). During a review of Health Facility Note (HN) 1, dated 12/3/2025, the HN1 indicated that Resident 76 had an unwitnessed fall to floor due to possible syncope (a sudden, temporary loss of consciousness and muscle control). The HN1 indicated to minor Resident 76`s small bump/abrasion to right (R) lateral head, redness to left (L) forehead, and small skin tear R great toe. During a concurrent interview and record review on 5/6/2026, at 1:53 p.m., with the Assistant Director of Nursing (ADON) and Registered Nurse (RN) 1, Resident 76's SBAR, HN, and the State Operations Manual (SOM, it provides detailed instructions, survey procedures, and interpretation of standards for state agencies to inspect healthcare facilities and ensure they comply with federal rules for Medicare/Medicaid payment) were reviewed. The ADON and RN 1 stated according to the SOM, the incident was reportable because the fall was not observed by anybody, Resident 76 was confused and cannot recount what had happened, and the resident had multiple injuries noted which made it unusual. The ADON and RN 1 also stated their policies and procedures (P&P) titled Accidents and Incidents- Investigating and Reporting and Unusual Occurrence Reporting were not followed because they did not report the incident to the state agency. During a concurrent (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview and record review on 5/7/2026, at 2:20 p.m., with the Administrator (ADM) and the Director of Nursing (DON), injury of unknown origin section of the SOM was reviewed. The ADM and the DON stated Resident 76`s unwitnessed fall should have been reported to the state agency, because nobody witnessed the resident`s fall, the resident was unable to explain due to confusion and the multiple injuries cannot be explained because nobody witnessed the incident. The ADM and the DON stated they would need to revise their policies and procedures of Unusual Occurrence Reporting and Accidents and Incidents- Investigating and Reporting to include the SOM's criteria for determining a case of injury of unknown origin and prompt reporting of the incident. The ADM and the DON stated the failure of the facility to report the unwitnessed fall constituting an injury of unknown origin had predisposed (increased risk of) the resident to suspected abuse that was not detected. During a review of the facility's recent P&P titled, Accidents and Incidents- Investigating and Reporting, last reviewed on 1/28/2026, the P&P indicted all accidents or incidents involving residents, employees, visitors, vendors, etc., occurring on our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation 1. The nurse supervisor/change nurse and/or department director or supervisor shall promptly initiate and document investigation of the accident or incident. 5. The nurse supervisor/charge nurse and/or the department director or supervisor shall complete a Report of Incident/Accident form and submit the original to the director of nursing services within 24 hours of the incident or accident. During a review of the facility's recent policy and procedure titled, Unusual Occurrence Reporting, last reviewed on 1/28/2026, the P&P indicated as required by federal or state regulations, our facility reports unusual occurrences or other reportable events which affect the health, safety, or welfare of our residents, employees or visitors. Policy Interpretation and Implementation 2. Unusual occurrences shall be reported via telephone to appropriate agencies as required by current law and/or regulations within twenty-four (24) hours of such incident or as otherwise required by federal and state regulations. 3. A written report detailing the incident and actions taken by the facility after the event shall be sent or delivered to the state agency (and other appropriate agencies as required by law) within forty-eight (48) hours of reporting the event or as required by federal and state regulations.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to submit a new Preadmission Screening and Resident Review level 1 (PASRR - a federal requirement to ensure that individuals with a mental disorder [MD - a person's mind makes it hard to think, feel, or act normally in daily living] or intellectual disability [ID - a person has trouble learning, understanding, or solving problems like most people their age] are properly screened and evaluated to determine appropriate placement and services in a nursing facility) for (1) of three (3) sampled residents (Resident 11), when Resident 11 was diagnosed by a Psychologist on 9/8/2026 with schizophrenia (a mental health condition that affects thinking, emotions, and understanding reality). This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for Resident 11.ˆˆˆ Findings:ˆ During a review of Resident 11's admission Record (AR), the AR indicated the facility originally admitted the resident on 9/4/2025 and readmitted on [DATE], with diagnoses including dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance (problems with memory, thinking and decision-making caused by another medical condition, the severity is not specified, and person also show behavior or mood changes); unspecified psychosis not due to a substance or known physiological condition (unusual thoughts or behavior that are not caused by drugs, alcohol, or another illness, and exact type is unknown); mild neurocognitive disorder due to known physiological condition with behavioral disturbances (a mild decline in thinking caused by a medical condition, accompanied by behavioral or mood changes, but the person remains for the most part independent). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool), dated 4/14/2026, the MDS indicated Residentˆ11 has the ability to make self-understood and can understand othersˆand had moderate cognitive impairment (has some memory or thinking difficulties but can still communicate and participate in daily activities with some assistance and reminders). The MDS indicated the resident was maximal to supervision assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a record review of Residentˆ11's PASRR Level I Screening, datedˆ9/2/2025, the PASRR Levelˆlˆ Screening indicated that the resident did not have a serious diagnosed mental disorder, no suspected mental illness, and has not been prescribed psychotropic (medications capable of affecting the mind, emotions, and behavior) medications.ˆ During a record review of Resident 11's Psychological Evaluation and Consultation, dated 9/8/2025, the Psychological Evaluation and Consultation indicated Resident 11 had a diagnosis of other specified schizophrenia spectrum and other psychotic disorder (is a mental health diagnosis used when a person has some symptoms of schizophrenia or psychosis, but not enough to fit a specific diagnosis). During a concurrent interview and record review on 5/7/2026 atˆ2:38 p.m.ˆwith MDS Coordinator (MDSC) 1, Resident 11's Admissionˆ Record, PASRR Level I Screening,ˆdatedˆ9/2/2025, and Psychological Evaluation and Consultation, dated 9/8/2025, were reviewed. MDSC 1 statedˆthat the admission RecordˆindicatedˆthatˆResident 11ˆhad a diagnosis ofˆunspecified psychosis during admission on [DATE]ˆand Residentˆ11's PASRR Level I Screeningˆindicatedˆthe resident did not haveˆserious mental illness, intellectual disability, developmental disability or related conditions and did not require a PASRR Level II Screening. MDSC 1 stated that the Psychological Evaluation and Consultation note indicated Resident 11 had a diagnosis of other specified schizophrenia spectrum and other psychotic disorder. MDSC 1 stated the PASARR is done before admission and is used to determine which facility is appropriate for resident to meet the resident's needs. MDSC 1 stated if the PASARR is not done resident will not get adequate care needed, specialized services, and needs may go unidentified. MDSC 1 stated if a new diagnosis of mental illness is diagnosed after admission then a new PASARR needed to be submitted. MDSC 1 stated that there is no new PASARR done for Resident 11. During an interview on 5/7/2026 atˆ3:11p.m.ˆwith the Director of Nursing (DON), the DON stated that if resident was diagnosed with an MD or ID after admission, then a new PASARR (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Level I should have been submitted to provide proper care, how to address diagnosis, appropriate referrals, and offer activities to the resident. The DON also stated that a care plan needs to be created so staff knows what interventions to do and resident's behavior. During a review of the facility's policy and procedure (P&P) titled, admission Criteria, last reviewed on 1/28/2026, the P&Pˆindicated 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a level 1 PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID or RD. b. If the level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process. (1) The admitting nurse notifies the social services department when a resident is identified as having a possible (or evident) MD, ID or RD. (2) The social worker is responsible for making referrals to the appropriate state-designated authority. c. Upon completion of the level II evaluation, the state PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure that the comprehensive care plan (a document outlining a detailed approach to care customized to an individual resident's need) is reviewed and revised by an interdisciplinary team (IDT, a group of experts from different fields like doctors, nurses, therapists, and social workers who work together closely to create a single, unified care plan for a patient) composed of individuals who have knowledge of the resident and his/her needs for one of thirteen sampled residents (Resident 76) reviewed for accidents by failing to review and revise the resident`s fall care plan to reflect an alleged unwitnessed fall on 12/3/2025.ˆ The deficient practice had the potential for delayed and unnecessary care for residents. Findings: During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted the resident on 6/9/2023, and readmitted the resident on 8/4/2025, with diagnoses including difficulty in walking, muscle weakness, and lack of coordination. During a review of Resident 76's History and Physical (H&P), dated 8/5/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 76's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had severe cognitive impairment (a significant, often permanent, loss of mental capacity-comparable to advanced Alzheimer's or dementia-where a person can no longer live independently, manage daily tasks (like feeding or dressing), or clearly communicate). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 76's Admission/readmission Data Tool (ADT), dated 12/5/2025, the ADT indicated the resident was at risk for falls. During a review of Resident 76's Situation, Background, Assessment, Recommendation (SBAR- a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 12/3/2025, the SBAR indicated that the resident was seen on the floor next to bed in side lying position on the right side holding bed remote control, confused as baseline, noted a small bump and abrasion (an injury where your skin rubs off) to right side lateral (side) head and a small skin tear to right great toe. During a review of Resident 76's Care Plan (CP) Report titled, The resident is at risk for Falls related to diagnosis of Parkinson's, severe protein-calorie malnutrition, . history of falls, incontinence, history of getting up and ambulate without asking or calling for assistance, trying to function beyond his capabilities, initiated on 8/5/2024, the CP did not reflect the actual fall that happened on 12/3/2025. During a concurrent interview and record review on 5/6/2026, at 2:44 p.m., with the Assistant Director of Nursing (ADON), Resident 76's ADT, SBAR, and CPs were reviewed. The ADON stated that the current care plan was not updated with the resident's unwitnessed fall on 12/3/2025. The ADON stated it was important to update the care plan with the current fall date to ensure additional interventions were added to prevent another fall. During an interview on 5/7/2026, at 2:20 p.m., with the Director of Nursing (DON), the DON stated Resident 76` care plan for fall should have been updated addressing the resident`s current fall on 12/3/2025. The DON stated it was the responsibility of all licensed nurses to update the care plan to reflect the current status of the resident. The DON stated that not updating the care plan with the current fall of the resident could potentially contribute to another fall of the resident. During a review of the facility's recent policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 1/28/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor and assess the healed pressure ulcer (localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device) on the affected site for one of one sampled resident (Resident 53). This deficient practice had the potential for reopening of healed pressure ulcer for Resident 53. Findings: During a review of Resident 53's admission Record, the admission record indicated that Resident 53 was initially admitted to the facility on [DATE] , with diagnoses including hypertension (high blood pressure), history of falling, cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body) and atrial fibrillation (an irregular and very rapid heart rhythm that and can lead blood clots in the heart). During a review of Resident 53's Minimum Data Set (MDS -ˆa resident assessmentˆtool), datedˆ04/20/2026, the MDS indicated that Resident 53's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆintact. The MDS indicated Residentˆ53ˆrequired partial to substantial physical assistanceˆfrom staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing).ˆThe MDS indicated the resident was at risk for developing pressure injuries. The MDS indicated that Resident 53 had one stage 2 pressure ulcers (a shallow, open sore or blister) and two stage 3 pressure ulcers (deep, open sore where the skin has fully broken down, exposing the fat layer underneath) that were present upon admission. During a review of Resident 53's Care Plan Report titled, possible wound recurrence of resolved left lateral buttock stage 2 pressure injury, left buttock stage 3 pressure injury and right buttock stage 3 pressure injury, initiated on 04/30/2026, the care plan indicated a goal to keep the skin intact by monitoring affected areas each shift and notifying the physician if breakdown occurs. During a review of Resident 53's Care Plan Report titled, at risk for pressure sore or potential for pressure ulcer development, revised on 4/16/2026, the care plan indicated a goal to minimize development of pressure injury by following facility's protocols for the prevention/treatment of skin breakdown. During an interview on 5/6/2026 at 1:10 p.m. with Resident 53, Resident 53 stated developing a pressure ulcer upon admission to an acute care hospital. Resident 53 expressed the belief that the ulcer has since healed. During a concurrent observation, interview, and record review on 5/6/2026 at 1:12 p.m. with Treatment Nurse (TN) 2, Resident 53's physician's order recapitulation report, skin issues assessment and care plan report were reviewed. TN 2 observed assessing the buttocks and he stated describing the buttocks as blanchable pinkish redness with dry, intact skin. TN 2 indicated that certified nursing assistants, charge nurses, registered nurses, and treatment nurses are responsible for ongoing skin assessment and monitoring. TN 2 added that there was no physician order for monitoring the skin after the wound healed, and the last documented skin assessment was on 4/27/2026. TN 2 emphasized the importance of monitoring healed pressure injuries due to the risk of reopening from weakened adipose tissue (body fat). TN 2 further stated that there was a care plan for Resident 53 to monitor affected areas every shift, although it was not implemented. TN 2 added that lack of continuous monitoring could result in worsening conditions before detection. During an interview on 5/6/2026 at 2:44 p.m. with Registered Nurse (RN) 1, RN 1 stated skin assessment should be done on admission and any skin changes. RN 1 stated the need for proper documentation and monitoring of healed pressure injuries to prevent wound from reopening. During an interview on 5/7/2026 at 2:12 p.m. with the Director of Nursing (DON), the DON stated that staff should monitor residents' skin after a pressure injury has healed to maintain integrity and prevent recurrence. The DON stated that ongoing monitoring and documentation are necessary to detect early signs of skin breakdown and avoid worsening conditions. During a review of facility's policy and procedure (P&P) titled, Prevention of Pressure Injuries, reviewed on 1/28/2026, the P&P indicated that ongoing monitoring requires evaluating, reporting, documenting skin changes, and regularly assessing the effectiveness of interventions.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure that the respiratory care provided to residents was consistent with professional standards of practice for one of one sampled resident (Resident 39) reviewed for respiratory care by failing to ensure Resident 39's oxygen via nasal cannula (a lightweight, flexible plastic tube that delivers extra oxygen (supplemental oxygen) directly into the nostrils via two small, comfortable prongs) tubing was labeled with the date it was last changed. The deficient practice had the potential for the resident to develop complications such as shortness of breath, desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: During a review of Resident 39's admission Record (AR), the AR indicated the facility admitted the resident on 8/22/2016, and readmitted the resident on 2/17/2025, with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), pneumonia (an infection/inflammation in the lungs), and acute respiratory failure (a sudden, life-threatening emergency where the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide from it) with hypoxia (a condition where your body tissues or organs do not receive enough oxygen to function proper). During a review of Resident 39's History and Physical (H&P), dated 2/18/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 39's Minimum Data Set (MDS, a resident assessment tool), dated 3/18/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities-such as memory, thinking, reasoning, and attention-are functioning normally, with no significant decline or impairment). The MDS indicated the resident was on oxygen therapy (a medical treatment that provides extra oxygen to people who cannot get enough through normal breathing, usually via a mask or tube). During a review of Resident 39's Order Summary Report (OSR), the OSR indicated an order for: 3/14/2026 Oxygen at two (2) liters per minute (liters/min, measures how much oxygen, in liters, is delivered from a device (concentrator or tank) to your lungs every 60 seconds) via nasal cannula continuously (may remove during ADL care) every shift. 11/23/2025 Change Oxygen Nasal Cannula every week (Q Wk) and if needed (PRN) (w/name & date label). Every day shift every Sun. During a review of Resident 39's Care Plan (CP) Report titled, The resident hasˆoxygenˆtherapy- continuously, last revised on 5/21/2025, the CP indicated an intervention to changeˆoxygenˆnasal cannula Q Wk on Sunday and PRN (w/name & date label). One time a day every Sunday. During a concurrent observation and interview on 5/4/2026, at 11:05 a.m., with Licensed Vocational Nurse (LVN) 4, inside Resident 39's room, observed Resident 39's oxygen via nasal cannula without a label. LVN 4 stated the oxygen tubing should be labeled with the date it was changed to know when to change them again for infection control purposes. During an interview and record review on 5/6/2026, at 1:44 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the oxygen tubing should be labeled with the date it was changed for infection control. The ADON stated they change the oxygen tubing every Sunday to prevent prolonged use, they could grow bacteria on the tubing if used for a long time and can get the resident sick. During an interview on 5/7/2026, at 2:20 p.m., with the Director of Nursing (DON), the DON stated the oxygen tubing of Resident 39 should be labeled with the date it was last changed for infection control. The DON stated to ensure the tubing was not more than a week. The DON stated the failure of not labeling the oxygen tubing with the date it was last changed had the potential for infection due to its prolonged use and if the tubing was damaged administration of oxygen therapy will not be effective. During a review of the facility's recent policy and procedure (P&P) titled, Departmental (Respiratory Therapy)- Prevention of Infection, last reviewed on 1/28/2026, the P&P indicated the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. Steps in the Procedure 6. Change the oxygen cannula and tubing every seven (7) days, or as needed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to effectively manage a resident's pain forˆone of oneˆsampled resident (Resident 12) by failing to reassess pain within one hour of administration of hydrocodone-acetaminophen (medication used for moderate to severe pain) oral tablet.ˆ This deficient practice placed Resident 12 at risk of inadequate pain relief and experienced health complications from their medication therapy.ˆ Findings: During a review of Resident 12's admission Record, the admission record indicated that Resident 12 was initially admitted to the facility on [DATE] , with diagnoses including end-stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis) with dependence of hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), cellulitis (bacterial skin infection), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine). During a review of Resident 12's Minimum Data Set (MDS -ˆa resident assessmentˆtool), datedˆ02/06/2026, the MDS indicated that Resident 12's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆintact. The MDS indicated Residentˆ12ˆrequired supervision to moderate physical assistanceˆfrom staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 12's History and Physical (H&P), dated 2/16/2026, the H&P indicated that Resident 12 was admitted due to swelling, blistering, and pain at the left upper extremity arteriovenous fistula (vascular access used for hemodialysis) site. The H&P also indicated that Resident 12 has mental capacity to make decisions. During a review of Resident 12's Order Summary Report (OSR), dated 5/07/2026, the OSR indicated a physician ordered the following medications: - Acetaminophen tablet 325 milligram (mg-unit of measurement) Give 2 tablet by mouth every 6 hours as needed for mild pain (1-3), initiated on 4/22/2026. - Hydrocodone-Acetaminophen Oral tablet 5-325 mg Give 1 tablet by mouth every 4 hours as needed for moderate pain (4-6), initiated on 4/22/2026. - Hydrocodone-Acetaminophen Oral tablet 10-325 mg Give 1 tablet by mouth every 4 hours as needed for severe pain (7-10), initiated on 4/22/2026. During a review of Resident 12's care plan report titled, acute pain, revised on 12/22/2025, the care plan indicated that the goal was to express sufficient pain relief or demonstrate their ability to manage pain if it is not fully alleviated, through the proper administration of prescribed medication, monitoring and documenting side effects and effectiveness, anticipating their need for pain relief, and responding promptly to any complaints of pain. During a concurrent observation and interview on 5/5/2026 at 08:07 a.m. with Resident 12, Resident 12 was alert, oriented, and sitting up in bed with a dry, intact dressing on the left upper arm connected to a wound vacuum-assisted closure (vac- portable medical devices that uses continuous suction to help with wound healing) device. Resident 12 stated that he was admitted for a dialysis access infection and expressed a desire for more consistent pain medication timing. Resident 12 stated that being confined to bed reduces control over his care, and the importance of improvements significantly impacts his well-being. During a concurrent interview and record review on 5/7/2026 at 11:46 a.m. with Registered Nurse (RN) 1, Resident 12's electronic Medication Administration (eMAR) Note were reviewed. RN 1 said pain reassessment is needed to check if the medication is effective. RN 1 stated that for oral pain medication, it should be done within 30 minutes to one hour after administration. The eMAR Note indicated the following: a. On 5/7/2026 at 12:24 a.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/7/2026 at 3:00 a.m. b. On 5/6/2026 at 7:47 p.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/6/2026 at 09:08 p.m. c. On 5/6/2026 at 3:31 p.m., (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/6/2026 at 4:47 p.m. d. On 5/6/2026 at 07:53 a.m., Hydrocodone/Acetaminophen tablet 5-325 mg 1 tablet was given and pain reassessment was done on 5/6/2026 at 10:21 a.m. e. On 5/5/2026 at 9:46 p.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/5/2026 at 11:24 p.m. f. On 5/5/2026 at 4:59 p.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/5/2026 at 6:29 p.m. g. On 5/5/2026 at 6:00 a.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/5/2026 at 07:30 a.m. h. On 5/4/2026 at 9:12 p.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/4/2026 at 10:18 p.m. i. On 5/4/2026 at 3:46 p.m., Hydrocodone/Acetaminophen tablet 10-325 mg 1 tablet was given and pain reassessment was done on 5/4/2026 at 5:11 p.m. During a continued interview on 5/7/2026 at 11:46 a.m., with RN 1, RN1 stated that pain was not consistently reassessed within 60 minutes for Resident 12. RN 1 further stated that lack of monitoring in a timely manner could result in ongoing pain, disrupted activities, changes in vital signs, and irritability. During an interview on 5/7/2026 at 2:12 p.m. with Director of Nursing (DON), the DON stated that nurses are assessing pain prior administering pain medication, then reassess the effectiveness of the medication within 30 minutes to an hour for oral medication. The DON stated that if the medication is ineffective, another option should be offered, or the physician be notified. The DON further stated that delayed reassessment may leave residents in pain. During a review of the facility's policy and procedure titled, Pain Assessment and Management, reviewed on 01/28/2026, the P&P indicated that acute pain or worsening chronic pain should be evaluated every 30 to 60 minutes after it begins and reassessed as needed until relieved.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that resident receives care and services for the provision of hemodialysis (HD - filtering the blood of a person whose kidneys are not working normally) consisted with professional standard of practice by not implementing the fluid restriction and monitor fluid intake and output for one of two sampled residents (Resident 12). This deficient practice had the potential to cause fluid overload (excess water in the body) or dehydrating (insufficient water in the body) for Resident 12. Findings: During a review of Resident 12's admission Record, the admission record indicated that Resident 12 was initially admitted to the facility on [DATE] , with diagnoses including end-stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that lifters waste and excess fluid from the blood] function stop functioning on a permanent basis) with dependence of hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), cellulitis (bacterial skin infection), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity) and spinal stenosis (narrowing of the spaces within the spine, which can put pressure on the nerves that travel through the spine). During a review of Resident 12's Minimum Data Set (MDS -ˆa resident assessmentˆtool), datedˆ02/06/2026, the MDS indicated that Resident 12's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆintact. The MDS indicated Residentˆ12ˆrequired supervision to moderate physical assistanceˆfrom staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing). During a review of Resident 12's History and Physical (H&P), dated 2/16/2026, the H&P indicated that Resident 12 was admitted due to swelling, blistering, and pain at the left upper extremity arteriovenous fistula (vascular access used for hemodialysis) site. The H&P also indicated that Resident 12 has mental capacity to make decisions. During a review of Resident 12's Order Summary Report (OSR), dated 5/07/2026, the OSR indicated dialysis scheduled time every Monday, Wednesday and Friday. During a review of Resident 12's Nutrition Assessment, dated 4/30/2026, the Registered Dietician (RD) recommended to add 1200 milliliter (ml-unit of measurement) fluid restriction daily. During a review of Resident 12's care plan report titled, nutritional/hydration problem or potential nutritional problem, revised on 04/30/2026, the care plan indicated interventions that includes 1200 ml fluid restriction and monitoring intake and record every meal. During a concurrent interview and record review with Registered Nurse (RN) 1 on 5/7/2026 at 11:46 a.m., the OSR, nutrition assessment and care plan report were reviewed. RN 1 stated that Resident 12's diet and fluid restriction are recommended by a dietary consultant, which according to the assessment it was a daily limit of 1200 ml. RN 1 stated there was no physician order or implementation for fluid restriction. RN 1 further stated the importance of limiting fluids due to Resident 12's risk of fluid overload and impaired kidney function, which may lead to edema, respiratory distress, and other complications. RN 1 stated the need to monitor fluid intake and output for Resident 12. RN 1 stated that there was a care plan in place but no implementation of the monitoring for fluid intake and output order exists. RN 1 added that monitoring intake and output helps determine appropriate treatment and identify if adjustments are necessary, especially to prevent complications like fluid imbalance or respiratory distress. RN 1 further stated that evaluating fluid intake and output allows assessment of treatment effectiveness and timely notification to the physician if modifications are required. During an interview on 5/7/2026 at 2:12 p.m. with the Director of Nursing (DON), the DON stated that fluid restriction is crucial for dialysis residents due to impaired kidney filtration, as it helps prevent fluid overload. The DON stated that monitoring intake and output is necessary to assess retention and adjust fluids accordingly. The DON further stated that without implementation of fluid restriction and monitoring of intake and output, resident may be at risks for respiratory issues, worsening kidney conditions, swelling affecting mobility, and cardiovascular (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	distress. During a review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident with, reviewed 1/28/2026, the P&P indicated The resident's comprehensive care plan will reflect the resident's needs related to ESRD/dialysis care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to accurately and safely provide pharmaceutical services to residents for one of one sampled resident (Resident 93) by failing to notify the pharmacist for review and proper labeling of a medication brought into the facility from an outside appointment prior to administration and failing to ensure the medication was incorporated into the resident's car plan. This deficient practice had the potential to result in medication errors, improper dosing, and adverse effects to the resident. Findings: During a review of Resident 93's admission Records (AR - the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the AR indicated the facility admitted Resident 93 on 3/9/2026, with diagnoses including pneumonia (an infection/inflammation in the lungs), malignant neoplasm of pancreas (pancreas [a gland behind the stomach that helps digestion and controls blood sugar] cancer), type II Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 93's Minimum Data Set (MDS - a resident assessment tool), dated 3/12/2026, the MDS indicated Resident 93 had moderate cognitive impairment (trouble with one or more mental functions, such as remembering, learning new things, focusing, or making decisions). The MDS indicated Resident 93 was dependent (helper does all of the effort) with toileting hygiene, shoer, lower body dressing and putting on/taking off footwear. During a concurrent observation, interview, and record review on 5/6/2026 at 10:55 a.m. with Licensed Vocational Nurse (LVN) 3 at the Station B medication cart a bottle of zenpep (a prescription medicine that replaces missing digestive enzymes in people whose pancreases cannot properly break down food) 25,000-79,000-105,000 unit with a name tag for Resident 93 was present. The zenpep label did not originate from the facility's pharmacy. LVN 3 stated Resident 93 had a doctor's appointment outside of the facility on 4/29/2026 and returned with a new prescribed medication. LVN 3 stated the label on the medication bottle was not generated by facility's pharmacy. LVN 3 further stated that it was the facility's protocol, when a resident returns with new medications, nurses are required to notify the physician and the facility pharmacist for review and proper relabeling of the medication prior to administration. LVN 3 reviewed Resident 93's Progress Notes. LVN 3 stated Resident 93's progress notes indicated no documentation of pharmacist notification or consultation regarding Resident 93's new medication. LVN 3 stated failure to properly relabel medications obtained from an outside source can potentially lead to medication errors, including incorrect dosing which may compromise resident's safety. LVN 3 reviewed Resident 93's care plan. LVN 3 stated there was no care plan documented for Zenpep. LVN 3 stated not developing a care plan for a new medication may lead to inconsistent administration and dosing errors. During an interview on 5/6/2026 at 2:30 p.m. with the Director of Nursing (DON), the DON stated that medications received from outside sources must be promptly reported to the physician, evaluated by the facility pharmacy, and properly labeled prior to administration in accordance with facility's protocol. The DON stated a comprehensive care plan must be developed and implemented to ensure safe medication management. The DON added failure to complete these steps may increase the risk of drug interactions and can result in staff not having clear guidance to provide consistent and appropriate care for the residents. During a review of facility's policies and procedures (P&P) titled, Pharmacy Services Overview, dated 1/28/2026, the P&P indicated, Pharmaceutical services consist of the processes of receiving and interpreting prescriber's orders; acquiring, receiving, storing, controlling, reconciling, compounding (e.g., intravenous [through a vein] antibiotics), dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals. Medications are received, labeled, stored, administered and disposed of according to all applicable state and federal laws and consistent with standards of practice.

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	055287	A. Building B. Wing	05/08/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent (%). Two medication errors out of 25 total opportunities contributed to an overall medication error rate of 8 % for one of four residents (Resident 45) observed during medication administration. For Resident 45, the facility failed to ensure: 1. The physician's order for vitamin B12 (a vitamin the body uses to make and support healthy nerve cells) dosage matched with the dosage for vitamin B12 available in the in-house supply. 2. Miralax (an Over-the-Counter [OTC - drugs you can purchase off the shelf at pharmacies, grocery stores, or online without a doctor's prescription] flavorless powder used to relieve occasional constipation) administered in accordance with physician orders, when Licensed Vocational Nurse (LVN) 2 poured powdered medication into the cup first and then added water up to the 8 oz (ounce - unit of measurement for weight) measurement line. These deficient practices had the potential for medication errors, including inaccurate dosing, ineffective treatment and potential adverse resident outcomes. Findings: During a review of Resident 45's admission Records (AR - the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the AR indicated the facility originally admitted Resident 45 on 10/18/2016, then readmitted on [DATE], with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia (difficulty swallowing). During a review of Resident 45's Minimum Data Set (MDS - a resident assessment tool) dated 3/4/2026, the MDS indicated Resident 45 had ability for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 45 was dependent (helper does all of the effort) with toileting hygiene, shower, lower body dressing, putting on/taking off footwear. During a concurrent observation, interview, and record review during medication administration on 5/6/2026 at 8:38 a.m. with LVN 2 and Resident 45, inside Resident 45's room, LVN 2 prepared: - Vitamin B12 500 mcg (micrograms - metric unit of measurement for mass/weight) two tablets via gastrostomy tube (G-tube - a small tube surgically placed directly into the stomach through the skin of the belly to deliver food, liquids, and medications). - Miralax 17000 mg (milligram - metric unit of measurement of mass/weight) by pouring 17000 mg Miralax powder into the cup first and then adding water up to the 8 oz measurement line. LVN 2 reviewed Resident 45's electronic Medication Administration Record (eMAR), dated 5/6/2026, for physician's orders clarification before medication administration. LVN 2 stated physician's order, dated 3/1/2024, indicated vitamin B12 1000mcg one tablet via G-tube one time a day for supplement. LVN 2 stated the physician's order was not matching with the available vitamin B12 500 mcg in-house supply. LVN 2 stated if the dosage of physician's order and the dosage of the available medications are different and not verified properly, the resident could receive double dose, which would lead to medication error and harm the resident. LVN 2 stated physician's order, dated 3/2/2024, indicated Miralax oral packet 17 gram, give 17 gram (17gram = 17000 mg) via G-tube one time a day for bowel management. Dissolve powder in 8 oz water. LVN 2 stated by pouring powder medication first and then adding water, the water volume was measured inaccurately. LVN 2 further stated that this practice could result in the medication being improperly diluted, potentially affecting its effectiveness. During an interview on 5/6/2026 at 2:30 p.m. with Director of Nursing (DON), the DON stated that the physician's orders must match the available medication dosage to ensure safe administration. Any discrepancy between the ordered dose and available supply can lead to confusion, potential medication errors, incorrect dosing, adverse reactions, and possible harm to the resident. The DON stated that it was important for medication to be administered using the instructed method: the prescribed amount of fluid should be measured first, followed by the addition of the powder. The DON stated if the powder is added before the liquid, the total fluid volume may be (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inaccurate, resulting in improper dilution and inconsistent medication concentration. During a review of facility's policies and procedures (P&P) titled, Adverse Consequences and Medication Errors, dated 1/28/2026, the P&P indicated, A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately document the placement of the low air loss mattress (LAL - a mattress designed to prevent and treat pressure wounds [localized damage to the skin and/or underlying tissue usually over a bony prominence]) for one of one sampled resident (Resident 53). This deficient practice had the potential not to receive the necessary care for prevention of pressure ulcers for Resident 53. Findings: During a review of Resident 53's admission Record, the admission record indicated that Resident 53 was initially admitted to the facility on [DATE] , with diagnoses including hypertension (high blood pressure), history of falling, cardiomyopathy (a disease of the heart muscle that makes it harder for the heart to pump blood to the rest of the body) and atrial fibrillation (an irregular and very rapid heart rhythm that and can lead blood clots in the heart). During a review of Resident 53's Minimum Data Set (MDS -ˆa resident assessmentˆtool) datedˆ04/20/2026, the MDS indicated that Resident 53's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆintact. The MDS indicated Residentˆ53ˆrequired partial to substantial physical assistanceˆfrom staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing).ˆThe MDS indicated the resident was at risk for developing pressure injuries. The MDS also indicated that Resident 53 had one stage 2 pressure ulcers (a shallow, open sore or blister) and two stage 3 pressure ulcers (deep, open sore where the skin has fully broken down, exposing the fat layer underneath) that were present upon admission. During a review of Resident 53's History and Physical (H&P), H&P indicated that resident 53 had the capacity to understand and make decisions. During a review of Resident 53's record titled, Order Recapitulation Report, dated 05/07/2026, the records indicated a physician order for specialty bed mattress (used for pressure relief) Setting at Comfort Level 3 or may adjust based on patient's comfort level. Monitor for placement and function every shift initiated on 4/16/2026. During a review of Resident 53's records titled, Medication Administration Record (MAR), dated 5/7/2026, the MAR indicated that licensed staff documented on the physician order for monitoring for placement and function of specialty bed mattress every shift: On 4/16/2026 11 p.m. to 7 a.m. shift until 4/30/2026 all shifts and on 5/1/2026 all shifts until 5/6/2026 7 a.m. to 3 p.m. shift. During a review of Resident 53's care plan report titled, refusal of specialty bed mattress for wound care, initiated on 4/22/2026, the care plan indicated a goal to prevent complications secondary to pressure ulcers. During a concurrent observation and interview on 5/06/2026 at 1:10 p.m. with Resident 53, Resident 53 did not have a LAL mattress. Resident 53 stated he has been refusing the mattress because of his experience of it. During a concurrent observation, interview, and record review on 5/6/2026 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 53's MAR was reviewed. LVN 2 stated monitoring the LAL mattress during her 7 a.m. to 3 p.m. shift from 5/4/2026 to 5/6/2026. LVN 2 stated she did not check the LAL mattress placement before documenting. LVN 2 was observed inspecting type of mattress for Resident 53 and stated that the LAL mattress was not in place. LVN 2 stated she should have confirmed placement prior to documentation. During an interview on 5/6/2026 at 2:44 p.m. with Registered Nurse (RN) 1, RN 1 stated that nurses should document what occurred or was present. During an interview on 5/7/2026 at 2:12 p.m. with the Director of Nursing (DON), the DON stated that nurses should document what they observe as per physician's orders and not record information that was not present. The DON added that accurate documentation is essential for resident care, as errors can negatively impact health outcomes, delay treatment, and pose risks to safety. During a review of facility's policy and procedure (P&P) titled, Charting and Documentation, reviewed on 1/28/2026, the P&P indicated Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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. 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 ensure the mobile linen cart was covered afterˆremovingˆneededˆlinen supplies observed during resident screening.ˆˆ This deficient practice had the potential to cause cross-contamination (when harmful germs, chemicals, or allergens are unintentionally transferred from one object, surface, or person to another) of infection among residents and staff. Findings: During an observation on 5/4/2026 at 10:25 a.m., observed Certified Nursing Assistant (CNA) 4 bring the mobile linen cart to Room A, opening the mobile linen cart getting all needed supplies for the resident. The mobile linen cart was left open facing the room of the resident. CNA 4 provided care to the resident without replacing the cover of the mobile linen cart. During a concurrent observation and interview on 5/4/2026 at 10:26 a.m. with the Central Supply (CS) and CNA 4, the CS stated the mobile linen cart was uncovered and unattended. The CS stated that CNA 4 should have replaced the cover of the mobile linen cart after getting her supplies to prevent contamination of the linen from external contaminants. CNA 4 stated she should have placed the cover back to prevent the linen from getting exposed to the environmental contaminants. During an interview on 5/6/2025 at 2:56 p.m. with the Assistant Director of Nursing (ADON), the ADON stated CNA 4 should have replaced the cover of the mobile linen cart to protect the linens from environmental contaminants. The ADON stated the failure of the staff to replace the cover of the mobile linen cart had the potential to spread infection to the residents in the facility. During an interview on 5/7/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated the mobile linen cart should have been replaced with a cover after getting all needed supplies to protect the linen from contaminants that can cause the resident to get sick. The DON stated leaving the mobile linen cart open to air can contaminate the linen and can transfer harmful bacteria or viruses to the resident. During a review of the facility's recent policy and procedure (P&P) titled, Laundry and Bedding, Soiled, last reviewed on 1/28/2026, the P&P indicated under Transport, indicated: 6. Clean linen is protected from dust and soiling during transport and storage to ensure cleanliness. During a review of the facility's recent P&P titled, Policies and Practices- Infection Control, last reviewed on 1/28/2026, the P&P indicated this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation 2. The objectives of our infection control policies and practices are to: a. prevent, detect, investigate, and control infections in the facility; b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic (ATB - a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic use protocols and a system to monitor antibiotic use for two of three sampled residents (Residents 39 and 2) reviewed for antibiotic use by failing to ensure: 1. Resident 39's Hiprex (a prescription medicine used to prevent or reduce the frequency of chronic urinary tract infections [UTIs - an infection in the bladder/urinary tract] had a duration of use and had monitoring for adverse effects. 2. Resident 2's Amoxicillin-Pot Clavulanate Oral Tablet (a combination antibiotic used to treat bacterial infections like sinusitis [the inflammation or swelling of the tissue lining your sinuses], pneumonia [an infection/inflammation in the lungs], ear infections, and skin infections) 875-125 milligrams (mg - a unit of weight) had monitoring for adverse effects (a harmful, unexpected, or unpleasant reaction caused by a medication, treatment, or procedure). These deficient practices had placed the residents at risk for adverse effects and multidrug resistant organisms (MDRO - are types of bacteria or germs that have developed the ability to withstand multiple, common antibiotics that used to kill them) resistance (means that a germ, like a bacteria or fungus, has evolved to a point where multiple drugs that once killed it are no longer effective) to antibiotics. Findings: 1. During a review of Resident 39's admission Record (AR), the AR indicated the facility admitted the resident on 8/22/2016, and readmitted the resident on 2/17/2025, with diagnoses including pneumonia, chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), and acute respiratory failure (a life-threatening condition that occurs when fluid leaks from small blood vessels in the lungs and builds up in the air sacs [alveoli]). During a review of Resident 39's History and Physical (H&P), dated 2/18/2025, the H&P indicated the resident had the capacity to make decisions. During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities-such as memory, thinking, reasoning, and attention-are functioning normally, without significant decline or impairment). The MDS did not indicate any urinary tract infection active diagnosis. During a review of Resident 39's Order Summary Report (OSR), dated 3/20/2025, the OSR indicated an order for Hiprex oral tablet 1 gram (gm - a unit of weight) (Methenamine Hippurate). Give 1 gram by mouth two times a day for UTI prophylaxis (PPX - measures designed to preserve health). During a concurrent interview and record review on 5/6/2026 at 1:30 p.m. with the Assistant Director of Nursing (ADON), Resident 39's MDS, OSR, Labs, and Care Plans (CP) were reviewed. The ADON stated the resident has Hiprex an anti-infective and the duration was indefinite. The ADON stated we need to have an end date to know if the medication is effective and to prevent overdose to medication and prevent drug resistance. The ADON stated there was no latest urinalysis (UA) and culture (a test that checks your urine for bacterial or fungal (yeast) infections) found and no MD documentation of prolonged use. The ADON stated there was no specific monitoring for adverse effect on the use of Hiprex and no care plan on its use. The ADON stated it was important to monitor for adverse effects of the medication to ensure it is working and helps in the adjustment of the dosage of the medication. During an interview on 5/7/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated Resident 39's Hiprex use should have an end date and should have monitoring for adverse effect of its use. The DON stated the physician should have ordered a UA & culture to determine the causative organism and order an appropriate antibiotic. The DON stated that the duration of antibiotic use helps to minimize the use of antibiotic to prevent MDRO resistance. The DON stated monitoring for adverse effects helps the provider on adjusting the dosage of the medication or its discontinuation. 2. During a review of Resident 2's AR, the AR indicated the facility admitted the resident on 6/30/2022, and readmitted the resident on 3/31/2026, with (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnoses including UTI, cellulitis of right lower limb (a common, often painful bacterial infection of the deeper layers of the skin and the underlying tissue on the leg, ankle, or foot), and sepsis (a life-threatening blood infection). During a review of Resident 2's H&P, dated 4/1/2026, the H&P indicated the resident was alert, awake, oriented to person, place, and time and had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understands others and had moderate cognitive impairment (a transitional stage between normal aging and dementia, involving noticeable memory or thinking problems that exceed typical age-related decline). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 2's OSR, dated 3/31/2026, the OSR indicated an order for Amoxicillin-Pot Clavulanate Oral Tablet 875-125 mg (Amoxicillin & Pot Clavulanate). Give 1 tablet by mouth every 12 hours for Cellulitis for 4 Days. During a review of Resident 2's CP Report regarding the resident had wound infection at the right lower leg cellulitis, last revised on 4/1/2026, the CP indicated an intervention to administer antibiotic therapy as ordered. Observe any adverse reactions. During a concurrent interview and record review on 5/6/2026 with the ADON, Resident 2's MDS, OSR, and CP were reviewed. The ADON stated Amoxicillin Clavulanate is a significant med. The ADON Stated the IP screens the appropriate use of the antibiotics and they have a pharmacy consultant for Antibiotic Stewardship. The ADON stated they need to monitor for adverse side effects of the use of the antibiotic. The ADON stated there was no specific monitoring for adverse effect of the antibiotic from 3/31/2026 to 4/42026. The DON stated the monitoring for adverse effects should be every shift. The ADON stated the failure of the staff to monitor for adverse effects of its use predisposes the resident at risk for medication error. The ADON stated it was important to monitor for adverse effect for early detection of uncomfortable symptoms so the doctors can intervene right away. During an interview on 5/7/2026 at 2:20 p.m. with the DON, the DON stated Resident 2's Amoxicillin Clavulanate use should have monitoring for adverse effects. The DON stated monitoring for adverse effects helps the provider on adjusting the dosage of the medication or its discontinuation. During a review of the facility's recent P&P titled, Antibiotic Stewardship, last reviewed on 1/28/2026, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Policy Interpretation and Implementation 4. If an antibiotic is indicated, prescribers will provide complete antibiotic orders including the following elements: d. Duration of treatment: (1) Start and stop date; or (2) Number of days of therapy. During a review of the facility-provided information on the use of Hiprex (methenamine hippurate tablets USP), revised 12/2017, the Information indicated to reduce the development of drug-resistant bacteria and maintain the effectiveness of HIPREX (methenamine hippurate tablets USP) and other antibacterial drugs, HIPREX should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. INDICATIONS To reduce the development of drug-resistant bacteria and maintain the effectiveness of HIPREX and other antibacterial drugs, HIPREX should be used only to treat or prevent infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. ADVERSE REACTIONS Minor adverse reactions have been reported in less than 3.5% of patient treated. These reactions have included nausea, upset stomach, dysuria, and rash. During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed on 1/28/2026, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Adverse Consequences An adverse consequence refers to an unwanted, uncomfortable or dangerous effect that drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may includeˆa. Adverse drug/medication reaction;ˆb. Side effect; c. Medication-medication interaction; orˆd. Medication-food interaction. 3. Residents receiving medication are monitored for adverse consequences. 4. Adverse consequences are promptly identified and reported.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to offer the pneumonia (a lung infection) vaccine (medication that helps protect against pneumococcal infections, including invasive disease) yearly when the resident refused the immunization onˆ10/11/2023 for one of 5 sampled residents (Resident 54) reviewed for immunizations. This deficient practice had the potential to place residents at risk for respiratory infection including pneumonia. Findings: During a review of Resident 54's admission Record (AR), the AR indicated the facility admitted the resident on 5/25/2020, and readmitted the resident on 11/20/2025, with diagnoses including pneumonia, adult failure to thrive (a general, rapid decline in an older person's physical and mental health that cannot be explained by a single disease), and personal history of coronavirus disease 2019 (COVID-19 - a disease that spreads primarily through air droplets when an infected person breathes, talks, coughs, or sneezes, causing symptoms ranging from mild [fever, cough, loss of taste/smell] to severe pneumonia). During a review of Resident 54's History and Physical (H&P), dated 11/21/2025, the H&P indicated the resident was A&O X 3 (Alert and Oriented Times 3, a medical shorthand used by doctors and nurses to describe a resident who is awake, aware of their surroundings, and knows three key pieces of information [self, date, location, and/or situation]), with tremors, and the resident had the capacity to make decisions. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 1/28/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities-such as memory, thinking, reasoning, and attention-are functioning normally and without significant impairment). The MDS indicated the resident was up to date with pneumococcal vaccine. During a review of Resident 54's Immunization Record (IR), the IR indicated the resident refused the pneumonia vaccine on 10/11/2023. During a concurrent interview and record review on 5/8/2026 at 9:23 a.m. with the Infection Preventionist (IP), Resident 54's Immunization Record on point click care (PCC - an electronic healthcare record) was reviewed. The IP stated the resident refused the pneumonia vaccine on 10/11/2023, however she (IP) cannot find any documentation to support the refusal if the risks and benefits were explained to the resident regarding his refusal to take the vaccine. The IP stated that refusals should be documented because they are vital for them and for safety and prevention. The IP stated the documentation is vital to make sure it was explained to them the risk and benefits of the refusal to take the vaccine. The IP stated it is their right to receive the vaccine every season and should be offered yearly. The IP stated they missed offering the vaccine for two seasons, for 2024 and 2025. The IP stated their failure to offer the pneumonia vaccine can predispose the resident to pneumonia and other respiratory infections. During an interview on 5/8/2026 at 1:49 p.m. with the Director of Nursing (DON), the DON stated the IP should have documented the refusal of the resident from getting the pneumonia vaccine to ensure the risks and benefits of refusing the vaccine was explained to the resident and the vaccine should have been offered yearly to protect the resident from getting pneumonia. During a review of the facility's recent policy and procedure (P&P) titled, Pneumococcal Vaccine, last reviewed on 1/28/2026, the P&P indicated all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation 3. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. 5. Residents/representatives have the right to refuse vaccination. If refused appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. 7. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of vaccination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facilityˆfailed toˆdocumentˆthe explanation of theˆrisk and benefits of refusingˆcoronavirus disease 2019 (COVID-19 - a highly contagious respiratory illness caused by the SARS-CoV-2 virus, which first emerged in late 2019) vaccines for one of five sampled residents (Resident 36) reviewed for immunizations. This deficient practice had the potential to place residents at risk for respiratory infection including COVID-19. Findings: During a review of Resident 36's admission Record (AR), the AR indicated the facility admitted the resident on 7/19/2024, and readmitted the resident on 2/16/2026, with diagnoses including protein-calorie malnutrition (a serious condition caused by not eating enough calories and protein, leading to significant muscle loss, weight loss, and fatigue) and personal history of antineoplastic chemotherapy (specialized medications designed to treat cancer by stopping or slowing the growth of cancer cells). During a review of Resident 36's History and Physical (H&P), dated 9/5/2024, the H&P indicated the resident had the ability to understand and make decisions. During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 4/20/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's mental abilities-such as memory, thinking, reasoning, and attention-are functioning normally and without significant impairment or decline). The MDS indicated the resident's COVID-19 vaccination was up to date. During a review of Resident 36's Immunization Record (IR), the IR indicated the resident refused the COVID-19 vaccine on 10/17/2025. During a concurrent interview and record review on 5/7/2026 at 9:23 a.m. with the Infection Preventionist (IP), Resident 36's MDS and IR were reviewed. The IP stated that the resident refused COVID-19 vaccine on 7/23/2024 and 4/2/2025 but she cannot find any documentation of explaining the risk and benefits of refusing the vaccine. The IP stated that refusals should be documented because they are vital for them and for safety and prevention of COVID-19. The IP stated it needs to be documented to make sure it was explained to them the risk and benefits of refusal. During an interview on 5/8/2026 at 1:49 p.m. with the Director of Nursing (DON), the DON stated the IP should have documented the refusal of the resident form getting the CVOID-19 vaccine to ensure the risks and benefits of refusing the vaccine was explained to the resident and the vaccine should have been offered yearly to protect the resident from getting COVID-19. During a review of the facility's recent policy and procedure (P&P) titled, Coronavirus Disease (COVID-19)- Vaccination of Residents, last reviewed on 1/28/2026, the P&P indicated each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated. Policy Interpretation and Implementation 3. COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee. 5. Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. 14. When COVID-19 vaccination requires multiple doses, the resident (or resident representative) is provided with current information regarding additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of additional doses. 19. If a resident requests vaccination, but missed earlier opportunities for any reason, the vaccine will be offered to that resident as soon as possible. Efforts to help the resident obtain vaccination are documented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055287	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Palms Care Center	13400 Sherman Way N Hollywood, CA 91605

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to have an effective pest control program when a dead cockroach was found on the bathroom floor for one of nine sampled residents (Resident 78). This deficient practice had the potential in transmitting harmful bacteria to the residents and Resident 78 feeling disturbed. Findings: During a review of Resident 78's admission Record, the admission record indicated that Resident 78 was initially admitted to the facility on [DATE] , with diagnoses including hypertension (high blood pressure), acute pancreatitis (condition characterized by inflammation of the pancreas [organ in the abdomen]) and acute kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood). During a review of Resident 78's Minimum Data Set (MDS -ˆa resident assessmentˆtool), datedˆ04/21/2026, the MDS indicated that Resident 53's cognitive (mental action or process ofˆacquiringˆknowledge and understanding) skills for daily decisionsˆwereˆintact. The MDS indicated Residentˆ78ˆrequired supervision to moderate physical assistanceˆfrom staffs for activities of daily living (ADLs - toileting hygiene, shower/bathing).ˆ During a concurrent observation and interview on 5/4/2026 at 10:55 a.m. with Resident 78, Resident 78 stated she found a cockroach in the bathroom. One dead cockroach was observed on her bathroom floor. Resident 78 stated feeling bothered about pest issues and stated that the facility should improve its cleaning practices. During an interview on 5/6/2026 at 2:44 p.m. with Registered Nurse (RN) 1, RN 1 stated that all staff are responsible for visually monitoring for pests. RN 1 stated that presence of pests indicates poor facility hygiene and may require thorough cleaning, as they could cause infections and make residents feel uncomfortable in their home due to issues like cockroach infestations. During an interview on 5/7/2026 at 2:12 p.m. with Director of Nursing (DON), the DON stated that the maintenance supervisor oversees pest control. The DON stated the presence of pests can harm residents, create infection control issues, cause distress, and spread disease-causing bacteria through cross-contamination. During a review of facility's Policy and Procedure (P&P) titled, Pest Control, reviewed 01/28/2026, the P&P indicated that an ongoing program is in place to keep the building free of insects and rodents.