STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055697	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure informed consent for psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) was obtained in accordance with the facility's policy and procedures for one of five sampled residents (Resident 6). This deficient practice placed Resident 6 at risk for experiencing unexpected and/or unwanted adverse effects or complications of the medications, including increased cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions), over sedation (excessive drowsiness, loss of response to verbal command, inappropriate movement, hearing abnormalities, visual disturbances, sweating, or nausea), and tardive dyskinesia (a chronic movement disorder that causes involuntary, repetitive movements in the body). Findings: During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's admitting diagnoses included dementia (a progressive state of decline in mental abilities) and anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities). During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 6 had severe cognitive impairments. The MDS indicated Resident 6 required partial to moderate assistance from staff for activities of personal hygiene and mobility while in bed. During a review of Resident 6's History and Physical (H&P), dated 3/12/2025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6's discontinued physician order, dated 12/10/2024, the physician order indicated Resident 6 received 50 milligrams (mg, a unit of dose measurement) of Seroquel (quetiapine fumarate, an antipsychotic medication that treats several kinds of mental health conditions) twice a day for psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). The order was discontinued on 5/7/2025. (continued on next page)

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

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

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's physician order, dated 5/7/2025, the physician order indicated Resident 6 was to receive 100 mg of Seroquel twice a day for psychosis. During a review of Resident 6's medical record titled Informed Consent - Psychoactive Medication, dated 5/7/2025, the record indicated informed consent for administration of Seroquel 100 mg twice a day was obtained from Resident 6. During an interview on 5/8/2025 at 2:10 p.m., with Nurse Practitioner (NP) 1, NP 1 stated informed consent for psychotropic medication was necessary prior to their administration because the resident/responsible party needed to be informed of their potential adverse effects (an unwanted and potentially harmful effect that occurs because of a medical treatment). NP 1 stated this included extrapyramidal symptoms (EPS, involuntary movements, muscle stiffness, and tremors), over sedation, and possible falls and accidents. NP 1 stated psychotropics were also particularly high-risk for elderly residents (residents [AGE] years of age or older). During an interview on 5/8/2025 at 1:58 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that when a dose of psychotropic medication was increased, the ordering provider (i.e., physician, nurse practitioner) was required to obtain a new informed consent for the increased dose. During a concurrent interview and record review, on 5/8/2025 at 2 p.m., with the ADON, Resident 6's record titled Informed Consent - Psychoactive Medication, dated 5/7/2025, was reviewed. The ADON stated the informed consent for Seroquel 100 mg twice a day was obtained from Resident 6. During a concurrent interview and record review, on 5/8/2025 at 2 p.m., with ADON, Resident 6's H&P dated 3/12/2025 was reviewed. The ADON stated the H&P indicated Resident 6 did not have decision making capacity and could not give informed consent for the increased dose of Seroquel. The ADON stated informed consent was required to be obtained because there were side effects of psychotropics, including dehydration, sedation, and accidents. During a review of the facility's policy and procedure (P&P) titled Psychoactive/Psychotropic Medication Use, dated 4/2025, the P&P indicated the resident or resident representative had the right to be informed, in advance, by the physician or other practitioner, of the risks and benefits of proposed care. The P&P indicated prior to administration of the psychotropic medication, the prescribing clinician (i.e. physician, NP) were to obtain informed consent prior to administration.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on observation, interview, and record review, the facility failed to ensure the needs and preference of two of 22 sampled residents (Resident 66 and Resident 50) were accommodated by failing to: 1. Ensure Resident 66's call light was kept within his reach. 2. Ensure Facility staff used a language interpreter when communicating with Resident 50. This deficient practice removed Resident 66's ability to exercise his right to request assistance from staff and removed Resident 50's ability to understand the care being provided to him. Findings: 1. During a review of Resident 66's Admission Record, the Admission Record indicated Resident 66 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 66's admitting diagnoses included dementia (a progressive state of decline in mental abilities), anxiety disorder (mental health conditions characterized by excessive fear and worry that can significantly impact daily life), and history of falling. During a review of Resident 66's Minimum Data Set (MDS, a resident assessment tool), dated 4/8/2025, the MDS indicated Resident 66 had severe cognitive impairments (a decline in mental processes like memory, attention, language, and reasoning). The MDS indicated Resident 66 was dependent on staff for activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily), and was dependent on staff for repositioning while in bed. During a concurrent observation and interview, on 5/5/2025 at 1:48 p.m., while at Resident 66's bedside, Resident 66's call light was observed resting on the left side of his bed, near his feet. Resident 66 was lying in a right-facing position. Resident 66 stated he could not reach his call light. During a concurrent observation and interview, on 5/5/2025 at 1:49 p.m., with Certified Nurse Assistant (CNA) 1, CNA 1 stated Resident 66 should be able to reach the call light to ensure he can ask for help. CNA 1 stated he could yell for help if he could not reach his call light. During a concurrent observation and interview, on 5/7/2025 at 8:24 a.m., while at Resident 66's bedside, Resident 66's call light was observed resting on the left side of his bed, below his hip near his feet. Resident 66 was lying in a right-facing position. Resident 66 stated he could not reach his call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 3:25 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the purpose of the call light was to allow residents to call for help. The ADON stated call lights should be within reach of the resident. The ADON stated nursing staff should ensure the call light is within the resident's reach before leaving the room. The ADON stated if the call light was not within reach, it could lead to accidents and potential delays in the provision of care. The ADON stated it could also lead to the residents' needs not being met. The ADON stated it was not acceptable for a resident to yell for help and stated yelling for help was not a dignified way to live. The ADON stated yelling could also negatively impact the quality of life for the resident's roommates because it would disrupt their sleep and did not create a homelike environment. During a review of the facility's policy and procedure (P&P) titled Answering the Call Light, revised 10/2010, the P&P indicated staff were to ensure the call light was within easy reach of the resident while they are in bed. 2. During a review of Resident 74's Admission Record, the Admission Record indicated Resident 50 was originally admitted on [DATE] and most recently readmitted on [DATE]. Resident 50's admitting diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), generalized muscle weakness, reduced mobility, and depression. During a review of Resident 50's History and Physical (H&P), dated 10/5/2024, the H&P indicated Resident 50 had the capacity to understand and make decisions. During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's preferred language was Cambodian and indicated Resident 50 needed or wanted an interpreter to communicate with doctors and healthcare staff. The MDS indicated Resident 50 had severe cognitive impairments and required substantial/maximal assistance from staff for ADLs and mobility. During an observation on 5/6/2025 at 8:49 a.m., while at Resident 50's bedside, Resident 50 was observed with slurred speech but was able to state he spoke Cambodian. No communication board (a sheet of symbols, pictures or photos that a person points to, to communicate with those around them) was readily observed at Resident 50's bedside. During a telephone interview on 5/7/2025 at 1:03 p.m., with Resident 50's Emergency Contact (EM) 1, EM 1 stated Resident 50 spoke Cambodian and only spoke a few words of English. EM 1 stated she sometimes came to visit Resident 50, and when she spoke to him in Cambodian, he understood what was being said. EM 1 stated it was hard for Resident 50 to talk, but he preferred for facility staff to speak to him in Cambodian. During an observation on 5/7/2025 at 1:21 p.m., at Resident 50's bedside, Resident 50 was observed sitting up in bed, holding a fork in his right hand and feeding himself lunch. No communication board was readily observed at Resident 50's bedside. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 1:26 p.m., with CNA 2, CNA 2 stated she explained and provided all of Resident 50's care in English. CNA 2 stated she thought Resident 50 spoke English because she heard him say yes, no, and here while providing care. CNA 2 stated staff looked at his facial expressions to determine if he was accepting of the care being provided and stated Resident 50 often appeared frustrated. CNA 2 stated the Charge Nurse (Licensed Vocational Nurse [LVN] 3) did not mention Resident 50 had any language needs. CNA 2 stated she had not used a communication board or an interpreter with Resident 50 during her shift. During an observation on 5/7/2025 at 1:33 p.m., while at Resident 50's bedside, CNA 2 spoke to Resident 50 in English to ask about collecting his lunch tray. Resident 50 looked at CNA 2 and did not respond. CNA 2 walked away without using an interpreter, communication board, or other interpretation method. CNA 2 walked away without collecting Resident 50's tray and exited the room. During an interview on 5/7/2025 at 1:44 p.m., with LVN 3, LVN 3 stated Resident 50 spoke Vietnamese. LVN 3 stated she did not use an interpreter to speak with Resident 50 or explain the care being provided. LVN 3 stated they did not provide Resident 50 with a communication board because he had left-sided weakness and might not be able to point to things. LVN 3 stated it was important to speak to residents in their preferred language to ensure that nursing assessments were accurate, and to ensure staff could adequately identify the residents' needs and address them. During an observation on 5/8/2025 at 9:46 a.m., while at Resident 50's bedside, Restorative Nurse Aide (RNA) 1 approached Resident 50's bedside. RNA introduced himself in English and asked Resident 50, Do you want to do exercises? in English. Resident 50 grunted in response to RNA 1's question but did not verbalize a clear Yes or No and did not nod his head to gesture Yes or No. During a concurrent interview and record review, on 5/7/2025 at 3:28 p.m., with the ADON, Resident 50's MDS dated [DATE] was reviewed. The ADON stated the MDS indicated Resident 50's preferred language was Cambodian and indicated he preferred to have an interpreter when communicating with doctors and healthcare staff. The ADON stated it was important to communicate with residents in their preferred language to ensure they could understand what healthcare staff were saying and explaining to them. The ADON stated accommodation of language preferences was required to provide dignified and resident-centered care. The ADON stated speaking a different language than what the resident preferred could result in them feeling like they were not understood, or that staff could not understand them. The ADON stated this could result in frustration and refusal of care. The ADON stated it was the resident's right to be informed of the care they were receiving and participate in the care being provided. The ADON stated that even if Resident 50 had left-sided weakness, a communication board could be offered and used. During a review of the facility's policy and procedure (P&P) titled Resident Rights, dated 2001, the P&P indicated residents had a right to be informed of, and participate in, their care planning and treatment. During a review of the facility's P&P titled Communication Language Barrier, revised 3/2017, the P&P indicated it was the facility's policy to assist and provide appropriate communication for residents who have barriers to communicate. The P&P indicated staff were to provide an interpreter or utilize visual aids such as communication boards, white boards, or tablets. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled Dignity, dated 2001, the P&P indicated residents were to be cared for in a manner that promoted and enhanced their sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The P&P indicated staff were to honor resident goals, choices, preferences, values, and beliefs.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, Licensed Vocational Nurse (LVN) 3 failed to notify the physician when one of 22 sampled residents (Resident 74) experienced seizures (sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) on 2/13/2025, 2/16/2025, 2/20/2025, 2/28/2025, 3/1/2025, and 3/14/2025. This deficient practice prevented Resident 74's physician from being able to make adjustments to Resident 74's plan of care to prevent recurring seizure activity. Findings: During a review of Resident 74's Admission Record, the Admission Record indicated Resident 74 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 74's admitting diagnoses included seizures (sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 74's MDS, dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment (a significant decline in thinking, learning, remembering, and other mental functions, to the point where individuals struggle with daily activities and may require assistance or supervision). The MDS indicated Resident 74 required substantial/maximal assistance from staff for mobility while in bed. During a review of Resident 74's active physician order, dated 2/12/2025, the physician order indicated Resident 74 was receiving Ativan (lorazepam, an anti-anxiety medication) as needed for seizures. During a review of Resident 74's Medication Administration Record (MAR), dated 2/1/2025 to 2/28/2025, the MAR indicated Resident 74 received Ativan on 2/13/2025, 2/16/2025, 2/20/2025, and 2/28/2025. During a review of Resident 74's Medication Administration Record (MAR), dated 3/1/2025 to 3/31/2025, the MAR indicated Resident 74 received Ativan on 3/1/2025 and 3/14/2025. During an interview on 5/7/2025 at 3:04 p.m., with LVN 3, LVN 3 stated Resident 74 had a history of seizures. LVN 3 stated that when a seizure occurs, they ensure the residents' safety then immediately report the seizure activity to the physician. During a concurrent interview and record review, on 5/7/2025 at 3:12 p.m., with LVN 3, Resident 74's MAR dated 2/1/2025 to 2/28/2025, and MAR dated 3/1/2025 to 3/31/2025, were reviewed. LVN 3 stated the MARs indicated Resident 74 received Ativan on 2/13/2025, 2/16/2025, 2/20/2025, 2/28/2025, 3/1/2025, and 3/14/2025. LVN 3 stated the Ativan was given for seizures. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/2025 at 3:17 p.m., with LVN 3, LVN 3 stated she did not document the seizure activity anywhere in Resident 7's medical record aside from the documented administrations of Ativan on the MAR. LVN 3 stated she followed the medication administration orders for Ativan but did not notify Resident 74's physician or complete Change of Condition (COC) assessments for the seizures. During an interview on 5/7/2025 at 3:21 p.m., with the Assistant Director of Nursing (ADON), the ADON stated a COC assessment should be completed each time a resident has a seizure. The ADON stated there should be a COC assessment because if seizures were occurring despite the resident taking medication to prevent them, notification from LVN 3 would likely prompt the physician to order blood tests to identify if the resident's anti-seizure medication needed to be adjusted. During a review of the facility's policy and procedure (P&P) titled Change in a Resident's Condition or Status, dated 2001, the P&P indicated the facility was to notify the physician of changes in the resident's medical/mental condition and/or status.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the facility failed to ensure the following were indicated for two of five sampled residents (Resident 6 and Resident 73): 1. Non-pharmacological interventions were attempted, and behavioral indications were present and documented prior to administering psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for Resident 6. 2. Specific behavioral indications were documented and monitored from 3/1/2025 to 5/7/2025 for Resident 73 before the administration of clonazepam (a medication used to treat anxiety disorder [a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities]) three times a day. These deficient practices placed Resident 6 and Resident 73 at risk for experiencing unwanted adverse effects or complications from the psychotropic medications, including increased cognitive impairment (problems with a person's ability to think, learn, remember, use judgment, and make decisions), over sedation (excessive drowsiness, loss of response to verbal command, inappropriate movement, hearing abnormalities, visual disturbances, sweating, or nausea), and tardive dyskinesia (a chronic movement disorder that causes involuntary, repetitive movements in the body). Findings: a. During a review of Resident 6's Admission Record, the Admission Record indicated Resident 6 was admitted to the facility on [DATE]. Resident 6's admitting diagnoses included dementia (a progressive state of decline in mental abilities) and anxiety disorder. During a review of Resident 6's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2025, the MDS indicated Resident 6 had severe cognitive impairments. The MDS indicated Resident 6 required partial to moderate assistance from staff for activities of personal hygiene and mobility while in bed. During a review of Resident 6's Change of Condition Assessment, dated 9/18/2024, the COC indicated Resident 6 exhibited episodes of anxiety manifested by agitation and restlessness. The COC did not indicate non-pharmacological interventions were provided to address the behaviors of agitation and restlessness. The COC indicated orders were received to administer 0.5 milligrams (mg, a unit of dose measurement) of Ativan (an anti-anxiety medication) every 12 hours as needed for anxiety. During a review of Resident 6's Medication Administration Record (MAR), dated 9/1/2024 to 9/30/2024, the MAR indicated Resident 6 received Ativan 0.5 mg on 9/25/2024 and 9/26/2024. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 6's MAR, dated 10/1/2024 to 10/31/2024, the MAR indicated Resident 6 displayed one episode of anxiety manifested by agitation and/or restlessness on 10/18/2024. No other episodes of anxiety were documented for the month of 10/2024, however the MAR indicated staff administered Ativan 0.5 mg for anxiety on 10/1/2024, 10/2/2024, 10/4/2024, 10/5/2024, 10/18/2024, 10/30/2024, and 10/31/2024. During a review of Resident 6's MAR, dated 11/1/2024 to 11/30/2024, the MAR indicated Resident 6 displayed no episodes of anxiety manifested by agitation and/or restlessness during the month of 11/2024, but indicated staff administered Ativan 0.5 mg for anxiety on 11/5/2024, 11/24/2024, and 11/25/2024. During a review of Resident 6's COC Assessment, dated 12/5/2024, the COC indicated Resident 6 was having episodes of outbursts and yelling. The COC did not indicate any non-pharmacological interventions were provided to address the behaviors of outbursts and yelling. The COC indicated an order was received for Seroquel (quetiapine fumarate, an antipsychotic medication that treats several kinds of mental health conditions) 100 mg twice a day for psychosis manifested by outbursts. During a review of Resident 6's MAR, dated 12/1/2024 to 12/31/2024, the MAR indicated Resident 6 displayed no episodes of outbursts. The MAR indicated Resident 6 received seven (7) doses of Seroquel 100 mg from 12/5/2024 to 12/10/2024, and received 41 doses of Seroquel 50 mg from 12/10/2024 to 12/31/2024. During a review of Resident 6's MAR, dated 1/1/2025 to 1/31/2025, the MAR indicated Resident 6 displayed one episode of outbursts on 1/22/2025. No other episodes of outbursts were documented for 1/2025. The MAR indicated Resident 6 received 62 doses of Seroquel 50 mg from 1/1/2025 to 1/31/2025. During a review of Resident 6's MAR, dated 2/1/2025 to 2/28/2025, the MAR indicated Resident 6 displayed no episodes of outbursts for the month of 2/2025. The MAR indicated Resident 6 received 56 doses of Seroquel 50 mg from 2/1/2025 to 2/28/2025. During a review of Resident 6's MAR, dated 3/1/2025 to 3/31/2025, the MAR indicated Resident 6 displayed one episode of outbursts on 3/9/2025. No other episodes of outbursts were documented for 3/2025. The MAR indicated Resident 6 received 62 doses of Seroquel 50 mg from 3/1/2025 to 3/31/2025. During a review of Resident 6's MAR, dated 4/1/2025 to 4/30/2025, the MAR indicated Resident 6 displayed no episodes of outbursts for the month of 4/2025. The MAR indicated Resident 6 received 59 doses of Seroquel 50 mg from 4/1/2025 to 4/30/2025. During a review of Resident 6's MAR, dated 5/1/2025 to 5/31/2025, the MAR indicated Resident 6 displayed two episodes of outbursts on 5/5/2025. No other episodes of outbursts were documented for 5/2025. The MAR indicated Resident 6 received 14 doses of Seroquel 50 mg from 5/1/2025 to 5/7/2025. During a review of Resident 6's COC Assessment, dated 5/7/2025, the COC indicated Resident 6 had an episode of outburst. The COC did not indicate any non-pharmacological interventions were provided to address the outburst. The COC indicated Nurse Practitioner (NP) 1 ordered Seroquel 100 mg twice a day for psychosis manifested by outbursts which was twice the amount of Resident 6's previous Seroquel order. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/6/2025 at 9:52 a.m., at Resident 6's bedside, Resident 6 was observed lying in bed, awake, alert. Resident 6 was calm and was not agitated or restless. During an observation on 5/8/2025 at 1:19 p.m., at Resident 6's bedside, Resident 6 was observed sitting up in a wheelchair feeding himself lunch. Resident 6 was calm, and was not observed as agitated, restless, or yelling. During an interview on 5/8/2025 at 1:27 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 6's mood was generally calm, but he was occasionally confused. LVN 1 stated he could become disoriented to where he was and would call for his brother. LVN 1 stated Resident 6 was easily re-oriented and stated that after staff re-oriented him he was ok and did not have any other mood or behavior issues. LVN 1 stated this behavior was likely due to his dementia diagnosis. LVN 1 stated non-pharmacological interventions, such as re-orientation, should be attempted to address Resident 6's behaviors before administering medication. During a concurrent interview and record review, on 5/8/2025 at 1:37 p.m., with the Assistant Director of Nursing (ADON), Resident 6's COC assessments, dated 9/18/2024 and 12/5/2024, were reviewed. The ADON stated the COC, dated 9/18/2024, indicated Resident 6 displayed agitation and restlessness and Ativan was ordered. The ADON stated there was no documentation prior to the COC assessment on 9/18/2024 indicating other occurrences of agitation and/or restlessness. The ADON stated there was no documentation indicating non-pharmacological interventions were attempted prior to getting orders for and administering Ativan. The ADON stated the COC, dated 12/5/2024, indicated Resident 6 had outbursts and Seroquel was ordered. The ADON stated there was no documentation prior to the COC assessment indicating other occurrences of outbursts. The ADON stated there was no documentation indicating non-pharmacological interventions were attempted prior to getting orders for and administering Seroquel. During an interview on 5/8/2025 at 1:45 p.m., with the ADON, the ADON stated Resident 6 had a diagnosis of dementia, and stated dementia could cause Resident 6's behaviors of agitation, restlessness, and outbursts. The ADON stated non-pharmacologic interventions could be taken to address these behaviors prior to the administration of psychotropics, including reorienting the resident, providing distractions, and ensuring a calm environment. The ADON stated non-pharmacological interventions should be attempted before psychotropic medications because the behaviors might be addressable without medications. The ADON stated Resident 6's was receiving Ativan and Seroquel as chemical restraints to control his behaviors. During a concurrent interview and record review, on 5/8/2025 at 1:49 p.m., with the ADON, Resident 6's COC assessment dated [DATE] was reviewed. The ADON stated the COC indicated Resident 6 had an episode of psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) manifested by an outburst. The ADON stated the COC did not indicate non-pharmacological interventions were attempted to address the episode. The ADON stated the COC indicated NP 1 ordered Seroquel 100 mg twice a day for the episode of outburst. During a concurrent interview and record review, on 5/8/2025 at 1:52 p.m., with the ADON, Resident 6's physician order for Seroquel 100 mg twice a day, dated 5/8/2025, was reviewed. The ADON stated the physician order indicated Resident 6 was to receive 100 mg of Seroquel twice a day, and stated his previous order was for 50 mg of Seroquel twice a day. The ADON stated an increase in dose would require a behavioral indication, and stated this behavior would be documented in Resident 6's MAR. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 5/8/2025 at 1:56 p.m., with the ADON, Resident 6's MARs dated 4/2025 and 5/2025 were reviewed. The ADON stated the MARs indicated Resident 6 had two episodes of outbursts on 5/5/2025, and no other documented outbursts for 4/2025 and 5/2025. The ADON stated there was no documentation indicating non-pharmacologic interventions were attempted. The ADON stated that administration of psychotropic medications, without a behavioral indication or without attempting non-pharmacological intervention first, could cause adverse effects in the resident, including oversedation and accidents. During an interview on 5/8/2025 at 2:10 p.m., with NP 1, NP 1 stated psychotropic medications were particularly high-risk for elderly residents (residents [AGE] years of age or older), and caution was needed when increasing the dose. NP 1 stated there should be behavioral indications for increasing the dose, and stated non-pharmacological interventions should be attempted first. NP 1 stated Resident 6's behaviors of agitation, restlessness, and yelling could be attributed to his diagnosis of dementia. During an interview on 5/8/2025 at 2:21 p.m., with NP 1, NP 1 stated he increased Resident 6's Seroquel dose from 50 mg twice a day to 100 mg twice a day based on a verbal report he received from the ADON. NP 1 stated the ADON told him Resident 6 was having episodes of yelling at others. NP 1 stated he did not review Resident 6's records, including the MAR and COC assessments, to verify the frequency of the behavior. NP 1 stated he did not review Resident 6's records to determine if non-pharmacological interventions had been attempted prior to increasing Resident 6's Seroquel dose. NP 1 could not state if he directly observed Resident 6 displaying any episodes of yelling prior to increasing Resident 6's dose of Seroquel. During an interview on 5/8/2025 at 3:16 p.m., with the ADON, the ADON stated that on 5/7/2025 she told NP 1 Resident 6 was screaming. The ADON stated this was based on reports she received from nursing staff. The ADON stated she did not review Resident 6's records to validate the frequency of the behaviors. The ADON stated there was no documentation in the medical record to indicate the necessity of Resident 6's current orders for Seroquel, or previous orders for Ativan. During a review of the facility's policy and procedure (P&P) titled Psychoactive /Psychotropic Medication Use, dated 4/2025, the P&P indicated residents were only to receive psychotropic medications when necessary to treat a specifically diagnosed condition that is documented in the medical record. The P&P indicated staff were to identify person-centered, non-pharmacological interventions, unless contraindicated, to meet the individual needs of the resident, and minimize or discontinue the use of psychotropic medication. The P&P indicated that before initiating or increasing a resident's dose of psychotropics, the medical record must contain clear documentation that the resident's distress persists and his or her quality of life is negatively affected and, unless contraindicated, that multiple, non-pharmacological approaches have been attempted and evaluated. b. During a review of Resident 73's Admission Record, the Admission Record indicated Resident 73 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety, depression (overwhelming feeling of hopelessness and sadness), insomnia (inability to sleep), and paraplegia (loss of movement and/or sensation, to some degree, of the legs). (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 73 required substantial assistance (helper does more than half of the effort) from staff for toileting hygiene, bathing, and lower body dressing personal and chair to bed transfers. During a review of Resident 73's History and Physical (H&P), dated 2/28/2025, the H&P indicated Resident 73 had the capacity to make medical decisions. The H&P indicated Resident 73 was a known psychoactive substance (drugs that alter a person's brain function and results in a change in perception, mood or behavior) abuser. During a review of Resident 73's Order Summary Report, dated 5/6/2025, the Order Summary Report indicated Resident 73 was ordered clonazepam oral tablet 1 milligram (mg- a unit of measurement) one tablet by mouth three times a day for anxiety disorder manifested by multiple concerns on 2/27/2025. During a review of Resident 73's Medication Administration Record (MAR), dated 3/2025 to 5/2025, the MAR indicated Resident 73 received clonazepam 1mg by mouth three times a day for anxiety manifested by multiple concerns from 3/1/2025 to 5/7/2025. The MAR indicated Resident 73 was monitored for anxiety manifested by multiple concerns from 3/1/2025 to 5/7/2025. During a concurrent interview and record review on 5/7/2025 at 9:50 a.m. with LVN 4, Resident 73's MAR, dated 5/2025, was reviewed. The MAR indicated Resident 73 was monitored for anxiety manifested by multiple concerns from 5/1/2025 to 5/7/2025. LVN 4 stated psychotropic medication orders were normally inputted into the electronic medical record (EMR) with a specific indication of use, or diagnosis, and specific behavioral manifestations (behavioral symptoms that are persistent or repetitive behaviors that are unusual, disruptive, inappropriate, or cause problems). LVN 4 stated that it was important to ensure specific behavioral manifestations were included in the orders so that the licensed nursing staff could monitor for an increase or a decrease of the frequency of specific behaviors. LVN 4 stated Resident 73's MAR did not indicate the licensed nurses had adequately documented the monitoring of specific behaviors. LVN 4 stated she was familiar with Resident 73's behaviors and had known Resident 73 to constantly ask repetitive questions. LVN 4 stated she would have revised Resident 73's orders to monitor for anxiety manifested by constant and repetitive questioning. LVN 4 stated the lack of monitoring for specific behaviors and the frequency of these behaviors placed Resident 73 at risk for being treated with a psychotropic medication for a prolonged duration of time. During a concurrent interview and record review on 5/8/2025 at 8:57 a.m. with the Director of Nursing (DON), Resident 73's Order Summary Report, dated 5/6/2025, was reviewed. The Order Summary report indicated Resident 73 was ordered clonazepam 1 mg three times a day for anxiety disorder manifested by multiple concerns on 2/27/2025. The Order Summary indicated Resident 73 was ordered monitoring for anxiety manifested by multiple concerns. The DON stated the licensed nurse, along with the physician, was to ensure the indication and specific behavioral manifestations were documented and monitored once an order for a psychotropic drug was transcribed. The DON stated he transcribed Resident 73's order for clonazepam into the EMR. The DON stated the current orders for the use of and behavioral monitoring of clonazepam did not specify exact behavioral manifestations because the phrase multiple concerns could have different interpretations. The DON stated the lack of specificity placed Resident 73 at risk for inappropriate care planning interventions and goals, inadequate behavioral monitoring, and had increased the potential for Resident 73 to be receiving the medication unnecessarily. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P), titled, Psychoactive, Psychotropic Medication Use, dated 4/2025, the P&P indicated the following: 1. The facility was to administer medications by following federal and state regulations if the medication was necessary to treat specifically diagnosed conditions and was appropriately documented in the medical record. 2. The Attending Physician and other staff will gather and document information to clarify, as possible, the resident's behavior, mood, function, and medical condition, specific symptoms, and risks to the resident and others. 3. Before initiating a psychotropic medication, the resident's symptoms must be clearly and specifically identified and documented.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47286 Based on interview and record review, the facility failed to ensure the Minimum Data Sets (MDS, a resident assessment tool) for two of 22 sampled residents (Resident 38 and 74) accurately reflected the care and services they received. This deficient practice resulted in the transmission of inaccurate data to the Centers for Medicare and Medicaid Services (CMS) regarding the above residents' health status and unique healthcare needs. This deficient practice also created the potential for Residents 38 and 74 to not receive the interventions needed to monitor the effectiveness of the care received. Findings: 1. During a review of Resident 38's Admission Record, the Admission Record indicated Resident 38 was originally admitted on [DATE] and most recently readmitted on [DATE]. Resident 38's admitting diagnoses included congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 38's physician order, dated 3/18/2024, the order indicated Resident 38 was to receive oxygen therapy, as needed, for shortness of breath. During a review of Resident 38's MDS, dated [DATE], the MDS indicated Resident 38 did not have cognitive impairments (a decline in mental abilities like memory, language, problem-solving, and attention). The MDS indicated Resident 38 required supervision and/or touch assistance from staff for dressing herself, performing activities of personal hygiene, and movement while in and out of bed. The MDS did not indicate Resident 38 received oxygen therapy while a resident. During an observation on 5/5/2025 at 10:11 a.m., while at Resident 38's bedside, Resident 38 was observed receiving oxygen therapy through a nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). During an interview on 5/7/2025 at 10:42 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated the purpose of the MDS was to create a profile of the resident. The MDSN stated the MDS guided the resident's plan of care. The MDSN stated the information indicated in the MDS allowed the interdisciplinary team to identify the necessary interventions to provide care to the resident. During a concurrent interview and record review, on 5/7/2025 at 10:48 a.m., with the MDSN, Resident 38's physician order for oxygen therapy, dated 3/18/2025, and MDS, dated [DATE], were reviewed. The MDSN stated the physician order indicated Resident 38 was on oxygen therapy and stated the MDS did not indicate Resident 38 was on oxygen therapy. The MDSN stated it was important to have an accurate MDS to ensure proper care can be provided to the residents. 2. During a review of Resident 74's Admission Record, the Admission Record indicated Resident 74 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 74's admitting diagnoses included seizures (sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 74's active physician order, dated 8/22/2024, the physician order indicated Resident 74 was receiving levetiracetam (an anticonvulsant medication). During a review of Resident 74's active physician order, dated 2/12/2025, the physician order indicated Resident 74 was receiving Ativan (lorazepam, an anti-anxiety medication) as needed for seizures During a review of Resident 74's MDS, dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment (a significant decline in thinking, learning, remembering, and other mental functions, to the point where individuals struggle with daily activities and may require assistance or supervision). The MDS indicated Resident 74 required substantial/maximal assistance from staff for mobility while in bed. The MDS did not indicate Resident 74 received anticonvulsants (medication used to prevent seizures) or anti-anxiety medications. During a review of Resident 74's Medication Administration Record (MAR), dated 3/1/2025 to 3/31/2025, the MAR indicated Resident 74 received levetiracetam every day of 3/2025. The MAR indicated Resident 74 received Ativan on 3/1/2025 and 3/14/2025. During a concurrent interview and record review, on 5/8/2025 at 8:57 a.m., with the MDSN, Resident 74's MDS dated [DATE] was reviewed. The MDSN stated the MDS did not indicate Resident 74's use of anti-anxiety and anticonvulsant medication. The MDSN stated it was important to know the medications Resident 74 was taking to monitor their effectiveness and to monitor for possible side effects. During a review of the facility's policy and procedure titled Resident Assessments, dated 2001, the P&P indicated information documented in the MDS assessments was to consistently reflect information in the progress notes, plans of care, and resident observations/interviews.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to initiate a care plan or have resident-centered interventions for three of six sampled residents (Residents 50, 8, and 16) when: 1. Resident 50's preference for an interpreter when communicating with doctors and healthcare staff was not included in his communication care plan. 2. Resident 8 did not have a care plan for the use of oxygen. 3. Resident 16 did not have a care plan for the use of oxygen. These deficient practices resulted in staff being unaware of Resident 50's preference for a Cambodian-speaking interpreter. These deficient practices had the potential for Resident 8 and 16 oxygen administration and potentially caused a delay and negatively affected the delivery of care. Findings: 1. During a review of Resident 50's Admission Record, the Admission Record indicated Resident 50 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE]. Resident 50's admitting diagnoses included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), generalized muscle weakness, reduced mobility, and depression (feeling of sadness). During a review of Resident 50's History and Physical (H&P), dated 10/5/2024, the H&P indicated Resident 50 had the capacity to understand make decisions. During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool) dated 3/18/2025, the MDS indicated Resident 50 had severe cognitive impairment (ability to think and reason. The MDS indicated Resident 50 required substantial/maximal assistance from staff for activities of daily living (ADLs, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) and mobility. The MDS indicated Resident 50's preferred language was Cambodian and indicated Resident 50 needed or wanted an interpreter to communicate with doctors and healthcare staff. During a review of Resident 50's care plan titled [Resident 50] has a communication problem .speaks a foreign language (Cambodian), dated 6/20/2023, the care plan indicated interventions included encouraging the resident to state his thoughts, and to anticipate and meet the resident's needs. The care plan did not address the need for the use of an interpreter. During an observation on 5/6/2025 at 8:49 a.m., at Resident 50's bedside, Resident 50 was observed with slurred speech but able to state he spoke Cambodian. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on 5/7/2025 at 1:03 p.m., with Resident 50's Emergency Contact (EM) 1, EM 1 stated Resident 50 spoke Cambodian and only spoke a few words of English. EM 1 stated she sometimes visited Resident 50, and when she speaks to him in Cambodian, the resident understands what is being said. EM 1 stated it was hard for him to speak, but he would prefer the staff to speak to him in Cambodian. During a interview on 5/7/2025 at 1:26 p.m., with Certified Nursing Assistant (CNA) 2, CNA 2 stated she explained and provided all of Resident 50's care in English. CNA 2 stated she thought Resident 50 spoke English because she heard him say yes, no, and here while providing care. CNA 2 stated staff looked at his facial expressions to determine if he was accepting of the care being provided and stated Resident 50 often looked frustrated. CNA 2 stated Licensed Vocational Nurse (LVN) 3 did not state Resident 50 required an interpreter. CNA 2 stated she had not used an interpreter to communicate with Resident 50. During an observation on 5/7/2025 at 1:33 p.m., at Resident 50's bedside, observed CNA 2 speaking to Resident 50 in English. Resident 50 did not respond. CNA 2 walked away without collecting Resident 50's tray and exited the room. During an interview on 5/7/2025 at 1:44 p.m., with LVN 3, LVN 3 stated Resident 50 spoke Vietnamese. LVN 3 stated she did not use an interpreter to speak with Resident 50 or explain care. LVN 3 stated it was best and important to speak to residents in their preferred language to ensure that assessments were accurate and to ensure staff could identify the resident's needs and address them. During an observation on 5/8/2025 at 9:46 a.m., at Resident 50's bedside, observed Restorative Nurse Aide (RNA) 1 approach Resident 50's bedside. RNA 1 introduced himself in English and asked Resident 50, Do you want to do exercises? in English. Resident 50 grunted in response to RNA 1's question but did not verbalize a clear yes or no and did not nod his head yes or no. During a concurrent interview and record review, on 5/7/2025 at 3:28 p.m., with the Assistant Director of Nursing (ADON), Resident 50's MDS dated [DATE] and care plan titled [Resident 50] has a communication problem .speaks a foreign language (Cambodian), dated 6/20/2023, were reviewed. The ADON stated the MDS indicated Resident 50's preferred language was Cambodian and indicated the resident preferred to have an interpreter when communicating with doctors and healthcare staff. The ADON stated the preference for an interpreter was not documented in Resident 50's care plan. The ADON further stated the current care plan interventions could not be implemented without the use of an interpreter as there were no staff who spoke Cambodian. The ADON stated accommodation of language preferences were required to provide resident-centered care. 2. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with chronic obstructive pulmonary disease ([COPD], a chronic lung disease causing difficulty in breathing)) and diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's History and Physical (H&P) dated 4/3/2025, the H&P indicated Resident 8 was alert (awake and alert to surroundings). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's MDS dated [DATE], the MDS indicated Resident 8's cognitive skills for daily decision making was intact. The MDS indicated Resident 8 required supervision for eating. The MDS indicated Resident 8 required moderate assistance (helper does less than half the effort) for oral hygiene. The MDS indicated Resident 8 was dependent on staff for toileting hygiene, and shower/bathing. The MDS indicated Resident required maximal assistance (helper does more than half the effort) for upper body dressing and personal hygiene. During a review of Resident 8's electronic medical record, unable to locate a care plan for Resident 8's oxygen administration. During a review of Resident 8's Order Summary Report, dated 4/27/2025, the order summary report indicated to administer oxygen at two liters per minute via nasal cannula (a small plastic tube, which fits into residents' nostrils for providing supplemental oxygen). During an interview on 5/7/2025 at 3:42 p.m. with the ADON, the ADON stated oxygen administration should be care planned. The ADON stated a care plan would provide an outline for Resident 8's care. During a concurrent interview and record review on 5/8/2025 at 3:37 p.m. with the Director of Nursing (DON), Resident 8's care plans were reviewed. The DON stated Resident 8 did not have a care plan for oxygen administration. The DON stated the care plan would serve as a plan of care for proper care, to prevent a decline, and maintain proper function. The DON stated if there was no care plan, Resident 8 would not have any interventions to maintain safe oxygen administration. The DON stated a care plan would outline how many liters per minute would be delivered to Resident 8, what was Resident 8's oxygen saturation (measurement of how much oxygen blood is carrying), the goal, and the side effects of receiving oxygen. 3. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE] with heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath) and peripheral vascular disease ([PVD], a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 16's History and Physical (H&P) dated 3/12/2025, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16's cognitive skills for daily decision making was intact. The MDS indicated Resident 16 required moderate assistance for eating. The MDS indicated Resident 16 required maximal assistance for oral hygiene, toileting hygiene, shower/bathing, dressing and personal hygiene. During a review of Resident 16's Order Summary Report, dated 12/19/2023, the order summary report indicated Resident 16 had an order to administer oxygen at two liters per minute via nasal cannula. (continued on next page)

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Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/8/2025 at 3:42 p.m. with the Director of Nursing (DON), Resident 16's care plans were reviewed. The DON stated Resident 16 did not have a care plan for oxygen administration. The DON stated Resident 16 needed a care plan for oxygen administration because it would inform licensed nurses why the resident needed oxygen, what to do if the oxygen saturation was lower than Resident 16's goal, and outline interventions to make oxygen therapy beneficial and safe. During a review of the facility's policy and procedure (P&P) titled Comprehensive Assessments, dated 2001, the P&P indicated comprehensive assessments (MDS) were conducted to assist in developing the comprehensive resident-centered care plans. During a review of the facility's P&P titled Care Plans, Comprehensive Person-Centered, dated 2001, the P&P indicated care plan interventions were to be derived from a thorough analysis of the information gathered as part of the comprehensive assessment.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 47286 Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 74) had orders to monitor for seizures (sudden, uncontrolled electrical disturbances in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) following his first seizure on 2/12/2025. This deficient practice placed Resident 74 at risk of experiencing injuries related to unwitnessed and/or undocumented seizures (e.g., falls, choking, low oxygen levels). Findings: During a review of Resident 74's Admission Record, the Admission Record indicated Resident 74 was originally admitted on [DATE] and was most recently readmitted on [DATE]. Resident 74's admitting diagnoses included seizures. During a review of Resident 74's Minimum Data Set (MDS), dated [DATE], the MDS indicated Resident 74 had severe cognitive impairment (a significant decline in thinking, learning, remembering, and other mental functions, to the point where individuals struggle with daily activities and may require assistance or supervision). The MDS indicated Resident 74 required substantial/maximal assistance from staff for mobility while in bed. During a review of Resident 74's Change of Condition (COC) assessment, dated 2/12/2025, the COC indicated Resident 74 had a seizure lasting three minutes. During a review of Resident 74's active physician orders, dated 4/28/2025, the orders indicated staff were to monitor Resident 74 for seizure activity every shift. During a concurrent interview and record review, on 5/7/2025 at 3:21 p.m., with the Assistant Director of Nursing (ADON), Resident 74's order for seizure monitoring dated 4/28/2025, was reviewed. The ADON stated there should have been orders to monitor Resident 74 for seizure activity after the first seizure episode on 2/12/2025. The ADON stated nursing staff should have contacted the doctor for orders. The ADON stated it was important to have an order for seizure monitoring to ensure Resident 74's safety. During a review of the facility's policy and procedure (P&P) titled, Seizures and Epilepsy - Clinical Protocol, dated 2001, the P&P indicated staff were to monitor the progress of individuals with a new seizure or a seizure disorder and periodically document the presence or absence of seizure activity.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to follow their Policy and Procedure (P&P) for Intravenous line ([IV] a thin, flexible tube placed inside a vein, usually in the arm or hand, to deliver fluids, medications, or nutrients directly into the bloodstream) care for one of eight sampled residents (Resident 87) by failing to: 1. Ensure Resident 87's left arm IV and IV dressing was changed per the physician's order. 2. Ensure Resident 87's right arm IV was assessed. These deficient practices increased Resident 87's risk of developing an infection (the invasion and growth of germs in the body), and caused pain and discomfort to Resident 87. Findings: During an observation on 5/5/2025 at 9:50 a.m., Resident 87's left arm IV was dated 4/28/2025. Resident 87's right arm IV's dressing was dislodged from the skin and the IV had blood on the tubing. The dressing was not dated. During an observation on 5/6/2025 at 1:06 p.m., Resident 87's left arm IV was dated 4/28/2025. Resident 87's right arm IV's dressing was dislodged from the skin and the IV had blood on the tubing. The dressing was not dated. During an observation on 5/7/2025 at 12:18 p.m., Resident 87's left arm IV was dated 4/28/2025. Resident 87's right arm IV's dressing was dislodged from the skin and the IV had blood on the tubing. The dressing was not dated. During a review of Resident 87's Admission Record, the Admission Record indicated Resident 87 was admitted to the facility on [DATE] with diagnoses including end stage of renal disease (a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) and diabetes mellitus ([DM] a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 87's History and Physical (H&P) dated 5/2/2025, the H&P indicated Resident 87 had the mental capacity to understand and make medical decisions. During a review of Resident 87's Minimum Data Set ([MDS] a resident assessment tool), dated 4/10/2025, the MDS indicated Resident 87's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 87 required moderate assistance (helper does less than half the effort) for toileting hygiene, shower/bathing, dressing, and personal hygiene. The MDS indicated Resident 87 required supervision for eating and oral hygiene. During a review of Resident 87's Order Summary Report, dated 4/30/2025, the order summary report indicated to check Resident 87's IV line every shift until 5/19/2025. The order summary report indicated to change the IV line, IV dressing and IV cap every three days. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 87's Comprehensive Skin Evaluation/Assessment, dated 4/30/2025, the Comprehensive Skin Evaluation/Assessment indicated Resident 87 had a right and left antecubital (area in front of the elbow) IV with bruising. The Comprehensive Skin Evaluation/Assessment indicated Resident 87's left antecubital was noted with bright purple bruising. The Comprehensive Skin Evaluation/Assessment indicated the right antecubital was noted with a dressing that appeared to be coming undone and appeared to be worn out. During an interview on 5/5/2025 at 10:42 a.m. with Resident 87, Resident 87 stated he had a right arm IV for a month. Resident 87 stated the IV caused him pain and discomfort especially when dressing. Resident 87 stated staff never changed the IV or IV dressing. Resident 87 stated staff did not use the IV for medication administration. Resident 87 stated he did not know why he still had a right arm IV. Resident 87 stated no one had assessed his right arm IV and he thought it looked dirty. During an interview on 5/7/2025 at 3:54 p.m. with the Assistant Director of Nursing (ADON), the ADON stated Registered Nurses (RNs) are responsible for assessing IV sites, changing IV site dressings and administering IV medication. The ADON stated RNs assessed the IV site for redness, dressing placement, infiltration (when IV fluids or medications leak out of the vein and into the surrounding tissues) and bleeding. The ADON stated IV lines and dressings must be changed according to the physician's orders. The ADON stated IV's lines and dressing must be changed every three to seven days. The ADON stated it was important to change the IV lines and IV dressings to prevent IV infections. The ADON stated licensed nurses must inform the physicians if an IV line or IV dressing was not changed every 3 days and document the reason why it was not changed. During a concurrent interview and record review on 5/7/2025 at 4:15 p.m. with the ADON, Resident 87's IV Administration Record was reviewed. The ADON stated the IV Administration Record indicated she (ADON) assessed Resident 87's IV site from 5/1/2025 to 5/2/2025 and 5/5/2025 to 5/7/2025. The ADON stated from 5/1/2025 to 5/7/2025, Resident 87's IV line and dressing had not been changed. During an interview on 5/7/2025 at 4:21 p.m. with the ADON, the ADON stated she assessed Resident 87's left IV line. The ADON stated she did not know the date the IV dressing was labeled. The ADON stated she was supposed to know the date the IV line was placed because that was part of her assessment. The ADON stated she did not know when she should change the IV line or IV dressing. The ADON stated she did not inform the physician that she did not change Resident 87's IV line and dressing. The ADON stated she did not verify with Resident 87's physician that it ok to keep the IV line and dressing for nine days. The ADON stated Resident 87 returned from the hospital on 4/29/2025 and he had an IV line on the left arm. The ADON stated Resident 87 had a right IV line before he was transferred (4/25/2025) to the hospital but it was removed at the hospital. During an interview on 5/8/2025 at 10:47 a.m. with the ADON, the ADON stated Resident 87 only had a left IV line. The ADON stated it was acceptable to have the same IV line up to three weeks without changing it or changing the IV dressing. The ADON stated when Resident 87's antibiotic medication was administered, licensed nurses must date and initial the IV tubing to indicate when the medication was given to Resident 87. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/8/2025 at 11:02 a.m. with the ADON, in Resident 87's room, Resident 87 was observed with an IV on his right arm. The ADON stated she did not know Resident 87 had an IV on his right arm. The ADON stated she thought the IV was removed when he was transferred to the hospital. The ADON stated the right arm IV had not been assessed or had a dressing change. The ADON stated the Treatment Nurse (TN) did not notify her of Resident 87's right arm IV. The ADON stated the TN must notify her of all IVs that residents have. The ADON stated she did not know how long Resident 87 had the right arm IV but he had it before he was transferred to the hospital on 4/25/2025. The ADON stated Resident 87 had the right arm IV for at least two weeks. The ADON stated the IV site did not look good, the IV tubing had blood, the IV site had bruising, the IV dressing was dirty and the IV dressing was peeling off and was hanging off the skin. The ADON states based on the IV appearance it had to be removed especially because the IV had not been flushed (injecting a small amount of saline solution (mixture of sterile water and salt) into the IV line to push out any residual medication or fluid). The ADON stated the staff missed Resident 87's right arm IV and someone should have noticed how bad it looked. During an interview on 5/8/2025 at 11:30 a.m. with the TN, the TN stated she did Resident 87's skin assessment when he returned to the facility from the hospital. The TN stated she documented Resident 87's left and right antecubital IV. The TN stated she assessed the right IV dressing and it looked old and worn out. The TN stated she documented her findings and informed the Director of Nursing (DON). The TN stated she did not inform the ADON about the right IV because registered nurses must do their own IV assessments. During an interview on 5/8/2025 at 3:49 p.m. with the DON, the DON stated on admission nurses must identify all IVs and document the location of the IVs. The DON stated it was important to document all IVs for continuity of communication and for the IVs to be monitored. The DON stated if an IV was not monitored it increased the chances of an infection. The DON stated it was a lack of communication Resident 87's right arm IV was missed. The DON stated if nursing staff did not know about the right arm IV, it meant that it was not monitored for infiltration, infection or if it was functioning. The DON stated the admitting nurse should have identified the right arm IV and documented the finding. The DON stated all IVs had to be changed every three days and seven days if the resident was a hard stick (a patient whose veins are difficult to access, leading to multiple attempts and potential complications). The DON stated IVs and IV dressings needed to be changed to prevent infection and for hygienic purposes. The DON stated if an IV or IV dressing was not changed as ordered, nurses must notify the physician. During a review of the facility's Policy and Procedure (P&P) titled Peripheral and Midline IV dressing changes, dated 3/2024, the P&P indicated the purpose for this procedure was to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. The P&P indicated to perform IV site care and dressing change at established intervals or immediately if the integrity of the dressing is compromised (damp, loosened or visibly soiled). The P&P indicated to change the dressing at least every seven days. The P&P indicated to assess the peripheral/midline access device at least every 8 hours, check for expiration dates of the infusion, dressing and administration set.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45009 Based on observation, interview, and record review, the facility failed to ensure residents received necessary respiratory care and services consistent with the resident's plan of care for three of 26 sampled residents (Resident 8, 16, 39). For Resident 8, who had a diagnosis of chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), there was no assessment of the oxygen saturation (measurement of the amount of oxygen in the blood). For Residents 8, 16 and 39, the prescribed liters of oxygen were not administered to the residents per the physician's order. These deficient practices had the potential to cause a negative respiratory outcome and placed residents at risk of injury due to fire hazard. Findings: 1. During a review of Resident 8's Admission Record, the Admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including COPD and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 3/21/2025, the MDS indicated Resident 8's cognitive skills for daily decision making was intact and required supervision for eating. The MDS indicated Resident 8 required moderate assistance (helper does less than half the effort) for oral hygiene and was dependent on staff for toileting hygiene, shower/bathing. The MDS indicated Resident 8 required maximal assistance (helper does more than half the effort) for upper body dressing and personal hygiene. During a review of the Physician's Order Summary Report, dated 4/27/2025, the order summary report indicated Resident 8 was to receive oxygen at two liters per minute via nasal cannula (a small plastic tube, which fits into residents' nostrils for providing supplemental oxygen), may titrate oxygen if saturation was less than 92%. During a review of Resident 8's Vital Signs Summary, dated 1/1/2025 to 4/29/2025, the Vital Signs Summary indicated Resident 8's oxygen saturations were between 96% - 98%. The Vital Signs Summary did not indicate Resident 8's oxygen saturations were less than 92%. During a review of Resident 8's electronic medical record, there was no documentation of the Vital Signs Summary for oxygen saturations dated from 5/1/2025 - 5/8/2025. During an observation on 5/5/2025 at 12:45 p.m., an observation on 5/6/2025 at 12:04 p.m., an observation on 5/7/2025 at 12:10 p.m., and an observation on 5/8/2025 at 9:02 a.m., in Resident 8's room, Resident 8 received four liters of oxygen per minute and there was no Oxygen in Use sign placed outside of Resident 8's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2025 at 11 a.m., the Assistant Director of Nursing (ADON) stated to titrate oxygen meant to increase the oxygen liters delivered to a resident to maintain oxygen saturation at a certain level. The ADON stated it was important to check oxygen saturation to make sure residents received enough oxygen, because residents' oxygen saturation could drop, even though they were receiving oxygen. During a concurrent interview and record review on 5/8/2025 at 11:06 a.m. with ADON, Resident 8's Vital Signs Summary, dated 4/1/2025 - 4/29/2025 was reviewed. The ADON stated that on 4/29/2025, Resident 8's oxygen saturation was 97% and she should receive two liters of oxygen instead of the four liters. The ADON stated the licensed nurse should have checked Resident 8's oxygen saturation during medication pass and documented it. During a concurrent interview and record review on 5/8/2025 at 11:10 a.m. with ADON, Resident 8's Vital Signs Summary, dated 5/1/2025 - 5/8/2025 was reviewed. The ADON stated Resident 8 oxygen saturation was not monitored on 5/1 - 5/8/2025. The ADON stated Resident 8's oxygen should have been monitored every day to ensure Resident 8 was receiving enough oxygen. During a concurrent observation and interview on 5/8/2025 at 11:15 a.m. with ADON, in the hallway in front of Resident 8's room, there was no Oxygen in Use sign outside of Resident 8's room. The ADON stated and agreed Resident 8 did not have an Oxygen in Use sign outside the room and all residents with oxygen therapy must have one to alert residents, visitors and staff to not smoke. The ADON stated all licensed nurses were responsible for placing this sign in the designated areas. The ADON stated Certified Nursing Assistants (CNA) were also responsible to report it to their charge nurse when they did not see the sign. During a concurrent interview and record review on 5/8/2025 at 3:37 p.m. with the Director of Nursing (DON), Resident 8's care plans were reviewed. The DON stated Resident 8 did not have a care plan for oxygen administration as the care plan would serve as a plan of care for proper care, to prevent a decline, and maintain proper function. The DON stated that since there was no care plan, Resident 8 did not have any interventions to maintain safe oxygen administration. The DON stated a care plan would outline the goal and the side effects of the resident receiving oxygen. 2. During a review of Resident 16's Admission Record, the Admission Record indicated Resident 16 was readmitted to the facility on [DATE] with diagnoses including heart failure (progressive heart disease that affects pumping action of the heart muscles, causes fatigue and shortness of breath) and peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs). During a review of the Physician's Order Summary Report, dated 12/19/2023, the order summary report indicated Resident 16 was to receive oxygen at two liters per minute via nasal cannula. During a review of Resident 16's History and Physical (H&P) dated 3/12/2025, the H&P indicated Resident 16 did not have the capacity to understand and make decisions. During a review of Resident 16' MDS, dated [DATE], the MDS indicated Resident 16's cognitive skills for daily decision making were intact and the resident required moderate assistance for eating. The MDS indicated Resident 16 required maximal assistance for oral hygiene, toileting hygiene, shower/bathing, dressing and personal hygiene. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/5/2025 at 10:36 a.m., and an observation on 5/6/2025 at 8:21 a.m., in Resident 16's room, Resident 16 received one liter of oxygen per minute and there was no Oxygen in Use sign placed outside of Resident 16's room. During an observation on 5/7/2025 at 3:21 p.m., in Resident 16's room, Resident 16 received 2.5 liters of oxygen per minute. During a concurrent interview and record review on 5/8/2025 at 3:42 p.m. with the DON, Resident 16's care plans were reviewed. The DON stated Resident 16 did not have a care plan for oxygen administration. The DON stated Resident 16 needed a care plan for oxygen administration because it would inform licensed nurses why the resident needed oxygen, what to do if the oxygen saturation was lower than Resident 16's goal, and outline interventions to make oxygen therapy beneficial and safe. 3. During a review of Resident 34's Admission Record, the Admission Record indicated Resident 34 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including COPD and sequelae of cerebral infarction (the long-term consequences or lasting effects of a stroke). During a review of the Physician's Order Summary Report, dated 3/27/2025, the order summary report indicated Resident 34 had an order for oxygen at two liters per minute via nasal cannula for COPD. During a review of Resident 34's H&P dated 3/28/2025, the H&P indicated Resident 34 had fluctuating capacity to understand and make decisions. During a review of Resident 34' MDS, dated [DATE], the MDS indicated Resident 34's cognitive skills for daily decision making were severely impaired and was dependent on staff for all activities of daily living. During a review of Resident 34's care plan titled, Oxygen Therapy, dated 6/27/2024, the care plan indicated the goal was for Resident 34 not to have signs and symptoms of poor oxygen absorption (process where oxygen, typically from inhaled air, enters the bloodstream within the lungs). The care plan interventions indicated to monitor signs and symptoms of respiratory distress (difficulty breathing, with signs like rapid or shallow breathing, and a low oxygen level in the blood), change resident position every two hours to facilitate lung secretion movement and drainage, and promote lung expansion and improve air exchange by positioning with proper body alignment. During an observation on 5/5/2025 at 11:37 a.m. in Resident 34's room, Resident 34 received three liters of oxygen per minute and there was no Oxygen in Use sign was placed outside of Resident 34's room. During an observation on 5/6/2025 at 12:49 p.m., and on 5/7/2025 at 11:56 a.m., in Resident 34's room, Resident 34 received 2.5 liters of oxygen per minute and there was no Oxygen in Use sign was placed outside of Resident 34's room. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2025 at 3:42 p.m., the ADON stated if a resident received less oxygen than what the physician ordered, the resident would not receive appropriate oxygen perfusion and may cause a change in the resident's mental status. The ADON stated when a resident received more oxygen than what the physician ordered, resident lungs could hyperinflate (air trapped in the lungs, causing shortness of breath, chest tightness and fatigue) and cause the resident to work harder to breathe. The ADON stated it was important to deliver the correct liters of oxygen to a resident, to follow the physician's order, and for oxygen therapy to be beneficial to the residents. The ADON stated all residents on oxygen therapy should have an Oxygen is Use sign outside their room to notify all resident, visitors and staff not to smoke to prevent a fire. The ADON stated if there was no sign outside of the residents' room it could potentially be a hazard to residents' safety. During an interview on 5/8/2025 at 3:19 p.m., the DON stated it was important to deliver the correct amount of oxygen to residents to make them comfortable and stabilize them when in respiratory distress. The DON stated not providing the correct liters of oxygen to a resident was not following the physician's order. The DON stated it was important to follow physician's orders to keep residents healthy and maintain residents at their normal functional level. The DON stated the facility provided an Oxygen in Use sign when a resident was on oxygen therapy to inform staff, residents and visitors not to smoke because oxygen was combustible and can cause a fire. During a review of facility's policy and procedure (P&P) titled, Oxygen Administration, dated 2/2024, the P&P indicated its purpose was for a safe oxygen administration, staff would verify the physician's orders for oxygen administration and review the resident care plan. The P&P indicated an Oxygen in Use sign would be placed outside of resident's room entrance door and an Oxygen in Use sign would be placed over resident's bed.

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Costa Del Sol Healthcare	1016 S. Record St. Los Angeles, CA 90023

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47858 Based on observation, interview, and record review, the licensed nursing staff failed to ensure the physician's orders to hold medications were followed, medications were administered timely, and medications administered were accurately documented for four of six sampled residents (Resident 5, 93, 84, and 89) when: 1. Resident 89's order to hold medications on scheduled dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) days was clarified with Nurse Practitioner (NP) 2. 2. Resident 93's newly prescribed dose of fluconazole (a medication used to treat fungal infections) was administered timely from 5/4/2025 to 5/6/2025. 3. Resident 93's Antibiotic (medication used to treat infection) Medication Count Sheet was accurate and complete to account for all 10 doses of Resident 93's ordered doses of fluconazole. 4. Resident 5's Pregabalin (a medication used to treat nerve pain) Medication Count Sheet was accurate and complete to account for all 28 doses. 5. Resident 84's Pregabalin Medication Count Sheet was accurate and complete to account for all 30 doses. These failures had the potential to result in a hypotensive crisis ([low blood pressure]- a condition in which the force of the blood pushing against the artery walls is too low) and hospitalization or death for Resident 89. These failures resulted in a two-day delay in the treatment of Resident 93's fungal infection. These failures also had the potential to result in missing or unaccounted doses of Fluconazole and Pregabalin, drug diversion (the illegal distribution or abuse of prescription drugs or their use for unintended purposes), medication errors, and overdose (receive higher than the prescribed amount). Findings: a. During a review of Resident 89's Admission Record, the Admission Record indicated Resident 89 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD- irreversible kidney failure), dialysis, and muscle weakness. During a review of Resident 89's Minimum Data Set ([MDS], a resident assessment tool), dated 4/22/2025, the MDS indicated Resident 89's cognitive skills (ability to think and reason) for daily decision making was intact. The MDS indicated Resident 89 was dependent on staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/2025 at 9:17 a.m. with Resident 89, Resident 89 stated his normal dialysis days were Tuesdays, Thursdays, and Saturdays. Resident 89 stated he was getting ready to go to his dialysis treatment session and the session was scheduled for 10 a.m. that morning. During a concurrent interview and observation on 5/6/2025 at 9:18 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 89's medication administration pass was observed. LVN 6 administered Resident 89 his ordered dose of nifedipine (a medication used to lower blood pressure) extended release (ER- drug is released slowly over time) tablet 30 milligrams (mg-a unit of measurement), carvedilol (a medication used to lower blood pressure) tablet 6.25 mg, and isosorbide mononitrate (a medication used to lower blood pressure) ER tablet 60 mg. During a concurrent interview and record review on 5/6/2025 at 9:30 a.m. with LVN 6, Resident 89's Physician Orders, dated 5/6/2025, were reviewed. The Physician Orders indicated medications were to be held on dialysis days, every Tuesday, Thursday and Saturday. LVN 6 stated she administered Resident 89's blood pressure (the pressure of circulating blood against the walls of blood vessels) medications and she should have held the medications and clarified the order with Nurse Practitioner (NP) 2. LVN 6 stated her interpretation of the order was to hold Resident 89's medications while Resident 89 was out of the facility for dialysis. During an interview on 5/06/2025 at 1:40 p.m. with NP 2, NP 2 stated he ordered to hold all medications on Resident 89's dialysis days. NP 2 stated the order was not clear and the order should have been clarified to read to hold blood pressure medications on dialysis days. NP 2 stated he would have expected the nurses to clarify the order with him to hold Resident 89's blood pressure medications on dialysis days. NP 2 stated it was the standard of practice for nurses to hold blood pressure medications prior to a resident's dialysis session. NP 2 stated there was potential for Resident 89 to lose too much fluid and to have his blood pressure significantly lowered. During a concurrent interview and record review on 5/8/2025 at 8:57 a.m. with the Director of Nursing (DON), Resident 89's Physician Orders, dated 5/6/2025, were reviewed. The DON stated LVN 6 should have held Resident 89's blood pressure medications and clarified the medication order with NP 2. The DON stated the administration of the blood pressure medications placed Resident 89 a risk for his blood pressure to drop significantly and for Resident 89 to become sick. b. During a review of Resident 93's Admission Record, the Admission Record indicated Resident 93 was originally admitted to the facility on [DATE] with diagnoses that included methicillin resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics) infection, urinary tract infection (UTI- an infection in the bladder/urinary tract), and hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body). During a review of Resident 93's History and Physical (H&P), dated 5/4/2025, the H&P indicated Resident 93 did not have the capacity to make medical decisions. During a review of Resident 93's Order Summary Report, dated 5/2025, the Order Summary Report indicated Resident 93 was ordered to start Fluconazole Oral Tablet 200 mg one time a day for a fungal infection for 10 days on 5/4/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/6/2025 at 3:02 p.m. with LVN 5, Resident 93's Antibiotic Medication Count Sheet, dated 5/2025, was reviewed. The Antibiotic Medication Count Sheet indicated there were nine doses left in Resident 93's bubble pack supply of fluconazole. LVN 5 stated the normal process was to prepare the medication and document the remaining doses in the Antibiotic Medication Count Sheet to account for all doses of the medication. During a concurrent interview and observation on 5/6/2025 at 3:02 p.m. with LVN 5, Resident 93's bubble pack supply of fluconazole was completely intact and had 10 doses remaining. LVN 5 stated she signed and documented the preparation of Resident 93's dose of fluconazole in Resident 93's Antibiotic Medication Count Sheet, but she forgot to physically administer Resident 93's dose of fluconazole. LVN 5 stated Resident 93's Antibiotic Medication Count Sheet was inaccurate because 10 doses remained in the bubble pack. LVN 5 stated she did not administer the Fluconazole as ordered and should have ensured the Antibiotic Medication Count Sheet was accurate. LVN 5 stated this placed Resident 93 at risk for a medication error, a delay in treatment, and could have led to an undetected controlled medication discrepancy. During a concurrent interview and record review on 5/8/2025 at 7:47 a.m. with LVN 1, Resident 5's Order Summary Report, dated 5/2025, was reviewed. The Order Summary Report indicated Resident 93 was ordered to start Fluconazole Oral Tablet 200 mg one time a day for fungal infections for 10 days on 5/4/2025. LVN 1 stated she was Resident 93's assigned LVN for the 7 a.m. to 3 p.m. shift on 5/4/2025. LVN 1 stated Resident 93's dose of fluconazole had not been delivered to the facility during her shift. LVN 1 stated she should have taken the ordered dose of fluconazole from the facility's emergency kit (e-kit) to administer to Resident 93 instead of waiting for the medication to be delivered by the pharmacy. LVN 1 stated she forgot to consider removing the fluconazole from the e-kit, and this delayed the treatment of Resident 93's fungal infection. LVN 1 stated the delay in treatment placed Resident 93 at risk for her fungal infection to spread throughout her body. During an interview on 5/8/202 at 8:57 a.m. with the DON, the DON stated a newly prescribed anti-infective should be supplied within four hours of the order. The DON stated Resident 93 ordered dose of fluconazole should have been taken from the e-kit and administered right away (on 5/4/2025). The DON stated this placed Resident 93 at risk for an untreated infection. c. During a review of Resident 5's Admission Record, the Admission Record indicated Resident 5 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 5's MDS, dated [DATE], the MDS indicated Resident 5's cognitive skills for daily decision making was intact. The MDS indicated Resident 5 required supervision when performing activities of daily living. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation, interview, and record review on 5/6/2025 at 3:02 p.m. with LVN 5, Resident 5's Pregabalin Medication Count Sheet, dated 5/2025, was reviewed. Observed Resident 5's bubble pack of pregabalin. The bubble pack had 23 doses remaining. The Pregabalin Medication Count Sheet indicated 24 doses of pregabalin remained in the bubble pack. LVN 5 stated she forgot to document the preparation of Resident 5's dose of pregabalin on the Pregabalin Medication Count Sheet. LVN 5 stated this placed Resident 5 at risk for a medication error, accidental overdose, and could have led to an undetected controlled medication discrepancy. d. During a review of Resident 84's Admission Record, the Admission Record indicated Resident 84 was admitted to the facility on [DATE] with diagnoses that included spinal stenosis (a condition characterized by the narrowing of spaces in the spine, which can compress the spinal cord and nerves), post dysenteric arthropathy (a specific type of inflammatory joint disease that occurs following a dysentery [a stomach disease] infection), and muscle weakness. During a review of Resident 84's MDS, dated [DATE], the MDS indicated Resident 84's cognitive skills for daily decision making was intact. The MDS indicated Resident 84 was dependent on staff for toileting hygiene, showering, lower body dressing, and putting on footwear. The MDS indicated Resident 84 required substantial assistance (helper does more than half of the effort) for bed mobility. During a concurrent observation, interview, and record review on 5/7/2025 at 9:50 a.m. with LVN 4, Resident 84's Pregabalin Medication Count Sheet, dated 5/2025, was reviewed. Observed Resident 84's bubble pack of pregabalin. The bubble pack had three doses remaining. The Pregabalin Medication Count Sheet indicated four doses of pregabalin remained in the bubble pack. LVN 4 stated she forgot to document the preparation of Resident 84's dose of pregabalin on the Pregabalin Medication Count Sheet. LVN 4 stated this placed Resident 84 at risk for a medication error and could have led to drug diversion. During an interview on 5/8/202 at 8:57 a.m. with the DON, the DON stated the normal process for the administration of controlled drugs was to prepare the controlled drug and document the remaining doses on the medication count sheet. The DON stated if the medication count sheet for the controlled drug was inaccurate issues could arise. The DON stated this would increase the risk for drug diversion or for a resident to accidentally miss a dose or receive a double dose. During a review of the facility's Policy and Procedure (P&P) titled, Administering Medications, dated 2001, the P&P indicated the facility was to ensure medications were administered in a safe and timely manner and as prescribed. The P&P indicated medications were to be administered within one hour of their prescribed time, unless otherwise specified. The P&P indicated the person preparing a medication that was identified as having potential adverse consequences for the resident should contact the prescriber or the resident's attending physician to discuss the concerns. During a review of the facility's P&P titled, Charting and Documentation, dated 2001, the P&P indicated medications administered and treatments or services performed were to be documented in the resident's medical record.

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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** 45009 Based on observation, interview, and record review, the facility failed to ensure two of three sampled residents (Resident 83 and Resident 87) were free from significant medication errors (one which causes the resident discomfort or jeopardizes his or her health and safety) by failing to: 1. Ensure licensed nurses held medications for Resident 83 and Resident 87 on scheduled hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) days per the physician orders. The deficient practice had the potential to result in a hypotensive crisis (low blood pressure) leading to harm or hospitalization . Findings: a. During a review of Resident 87's Admission Record, the Admission Record indicated Resident 87 was admitted to the facility on [DATE] with diagnoses of end stage of renal disease (ESRD, a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life) and diabetes mellitus ([DM]- a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 87's History and Physical (H&P) dated 5/2/2025, the H&P indicated Resident 87 had the mental capacity to understand and make medical decisions. During a review of Resident 87's Minimum Data Set ([MDS] a resident assessment tool), dated 4/10/2025, the MDS indicated Resident 87's cognitive skills for daily decision making was intact (ability to think and reason). The MDS indicated Resident 87 required moderate assistance (helper does less than half the effort) for toileting hygiene, showering/bathing, dressing, and personal hygiene. The MDS indicated Resident 87 required supervision for eating and oral hygiene. During a review of Resident 87's Order Summary Report, dated 4/30/2025, the order summary report indicated to hold medications on dialysis days. During a review of Resident 87's Medication Administration Record (MAR), dated 5/1/2025 - 5/7/2025, the MAR indicated medications were to be held on Resident 87's dialysis days. The MAR indicated on 5/2/2025 and 5/5/2025 Resident 87 received the following: 1. Protonix 40 milligrams ([mg], unit of measurement) for gastroesophageal reflux disease ([GERD] digestive disease in which stomach acid or bile irritates the food pipe lining). 2. Docusate (stool softner) 100 mg. 3. Ferrous sulfate (supplement) 325 mg. 4. [NAME]-Vite (supplement). (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Thiamine (supplement) 100 mg. 6. Furosemide (medication used to remove excess fluid from the body) 100 mg. During a concurrent interview and record review on 5/7/2025 at 4:15 p.m. with the Assistant Director of Nursing (ADON), Resident 87's MAR dated 5/1/2025 - 5/7/2025 was reviewed. The ADON stated when there was an order to hold medication on dialysis days it meant to hold blood pressure medications (drugs used to treat high blood pressure). The ADON stated she did not know Resident 87 was not ordered blood pressure medication. The ADON stated based on Resident 87's MAR, all medications should be held because the order did not identify which medication to hold. The ADON stated on Resident 87's dialysis days the resident received all his medications. The ADON stated based on the MAR, furosemide should have not been given to Resident 87 because it would lower Resident 87's blood pressure and his dialysis treatment would potentially lower his blood pressure as well. The ADON stated licensed nurses should have contacted Resident 87's physician to clarify which medication was ordered to be held. The ADON stated licensed nurses did not follow the physician order. The ADON stated it was important to follow the physician's order for resident safety, prevent health complications, and maintain a better quality of life. During an interview on 5/8/2025 at 11:47 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated when there was an order to hold medications on dialysis days it meant to hold all medications on the days a resident has dialysis. LVN 4 stated she was not aware Resident 87 had an order to hold his medications on his dialysis days. LVN 4 stated she administered medications to Resident 87 on his dialysis days. LVN 4 stated if she was aware of the order she would have held all of Resident 87's medications because the order did not specify which medications to hold. LVN 4 stated by not holding all medications she did not follow the physician's order. LVN 4 stated it was important to follow the physician's orders to prevent health complications. During an interview on 5/8/2025 at 3:28 p.m. with the Director of Nursing (DON), the DON stated when there was an order to hold medications on dialysis days, they must hold all medications. The DON stated if a nurse needed clarification on a medication order they must call the residents physicians. The DON stated nurses did not follow the physician's order because medications were administered to Resident 87 on his dialysis days. The DON stated if a medication was not held it could potentially lower the residents' blood pressure and cause complications while at dialysis. 52406 b. During a review of Resident 83's Admission Record, the admission record indicated the facility admitted Resident 83 on 1/28/2025 with diagnoses including but not limited to ESRD, chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and DM. During a review of Resident 83's MDS, dated [DATE], indicated Resident 83's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 83 required hemodialysis. During a review of Resident 83's Dialysis Care Plan, initiated on 1/29/2025, the care plan indicated to hold blood pressure medications as ordered by the physician. During an interview on 5/7/2025 at 9:20 a.m. with Resident 83, Resident 83 stated he received his blood pressure medications and was getting ready to go to his dialysis appointment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/7/2025 at 9:31 a.m. with LVN 1, Resident 83's physician's orders dated 5/7/2025, and electronic Medication Administration Record (eMAR), dated 4/18/2025 to 5/7/2025, were reviewed. LVN 1 stated she administered carvedilol (used to treat heart failure and hypertension) oral tablet 12.5 milligram (mg, unit of weight), nifedipine (used to treat high blood pressure and to control chest pain) ER (externed release) oral tablet 60 mg, and hydralazine (used to treat high blood pressure) oral tablet 25 mg at 9:00 a.m. to Resident 83 on 4/19/2025, 4/22/2025, 4/26/2025, 5/3/2025 and 5/6/2025. LVN 1 stated she did not check the physician's orders before administering Resident 83's blood pressure medications. LVN 1 stated this error placed Resident 83 at risk for hypotension and bradycardia (slowed heart rate). During a concurrent interview and record review on 5/7/2025 at 9:33 a.m. with Registered Nurse (RN) 1, Resident 83's physician's orders dated 5/7/2025, and eMAR, dated 4/18/2025 to 5/7/2025, were reviewed. RN 1 stated LVN 1 should have held the blood pressure medications on 4/19/2025, 4/22/2025, 4/26/2025, 5/3/2025 and 5/6/2025 as ordered by the physician. During an interview on 5/7/2025 at 1:20 p.m. with the DON, the DON stated LVN 1 should have held the blood pressure medications on Resident 83's dialysis days. The DON stated the administration of blood pressure medications on Resident 83's dialysis days placed Resident 83 at risk for dizziness and passing out during his dialysis session. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 2001, the P&P indicated, Medications would be administered in a safe, timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame.