STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055704	A. Building B. Wing	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Angels Nursing Health Center	415 S Union Avenue Los Angeles, CA 90017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices to provide a safe, sanitary, and comfortable environment for one of two sampled medication carts (Medication cart 2) and for two of five sampled residents (Resident 34 and Resident 59) by failing to ensure:-Licensed nurses (in general) cleaned the pill cutter (safely and accurately cut medication tablets in half) in Medication Cart 2 and ensured the pill cutter did not have medication residuals inside the pill cutter.-Licensed Nurses (in general) labeled Resident 34's breathing treatment (a nebulizer machine that turns liquid medicine into a mist for inhalation) tubing and mask with date and ensure the tubing and mask were not on the floor.-Licensed Vocational Nurse 2 (LVN 2) wore a gown and gloves when checking Resident 59's blood pressure.These failures resulted in inadequate infection prevention practices. Findings: During a concurrent observation and interview on 6/9/2026 at 1:22 PM with LVN 3, observed a pill cutter in Medication Cart 2 with white particles and a piece of an unknown tablet left inside the pill cutter. LVN 3 stated that they (licensed nurses in general) were supposed to clean after each use and discard the remaining tablet per facility policy. LVN 3 stated there was a risk of infection and the possibility of medication interactions when the pill cutter was not properly cleaned after each use. During an interview on 6/11/2026 at 12:17 PM with the Director of Nursing (DON), the DON stated that the pill cutter should be cleaned between use and the remaining tablet should be disposed per facility policy due to possible cross contamination (the process by which a harmful or dirty substance spreads from one area to another) and not safe for the residents. During a review of the facility's Policy and Procedure (P&P) titled, Infection Prevention and Control Program, reviewed on 12/30/2025, the P&P indicated that the facility must establish an Infection Prevention and Control Program under which it – A. Identifies, investigates, control, and prevents infections in the Facility. During a review of the facility's P&P titled, Preparation and General Guidelines: Medication Administration-General Guidelines, reviewed on 12/30/2025, the P&P indicated that when using only one-half of the tablets from a unit-dose package, the remainder is disposed per facility policy. During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 4/24/2026 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should). (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's Medication Administration Record (MAR-facility report detailing the drugs administered to a resident by a licensed nurse) dated 4/24/2026, the MAR indicated an order for Ipratropium Bromide (breathing treatment medication that stops mucus and opens up airway) 0.02 percent (%) one unit via inhalation every four hours as needed for wheezing (whistling sound or coarse rattle sound when airway is partially blocked during inhalation) or shortness of breath. The MAR indicated that Ipratropium Bromide was administered on 5/29/2026 at 8:15 PM. During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 34 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to Supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent observation and interview on 6/8/2026 at 9:47 AM with LVN 1, breathing treatment mask and tubing were found on the floor unlabeled with date. LVN 1 stated breathing treatment mask and tubing were supposed to be inside a bag and with labeled date when it was opened. LVN 1 also stated that the set up for the breathing treatment was supposed to be changed once a week due to infection control. During an interview on 6/11/2026 at 8:34 AM with the DON, the DON stated that breathing treatment mask and tubing were not supposed to be on the floor. DON also stated breathing treatment mask and tubing were supposed to be inside respiratory bag and dated due to possible infection control issues. During a review of the facility's P&P titled, Oxygen Administration, reviewed on 12/30/2025, the P&P indicated under infection control that all oxygen tubing, humidifiers, masks and cannulas will be changed weekly and when visibly soiled. The P&P also indicated that oxygen items will be stored in a plastic bag at the resident's bedside to protect the equipment from dust and dirt when not in use. During a review of Resident 59's admission Record, the admission Record indicated the facility originally admitted Resident 59 on 11/6/2025 and re-admitted on [DATE] with diagnoses including end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis) and dependence on Hemodialysis (HD-a life-sustaining treatment for kidney failure that acts as an artificial kidney, filtering waste, toxins and excess water from the person's body using a machine) During a review of Resident 59's Order Summary Report dated 5/27/2026, the Order Summary Report indicated Resident 59 was on enhanced barrier precautions (EBP-infection control strategy for nursing home, requiring gowns and gloves to be used during high-contact care for residents with or at high risk for multidrug-resistant organisms [MDRO,microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents)]). The Order Summary Report indicated that providers and staff must wear gloves and gown with high-contact care activities. During a review of Resident 59's History and Physical (H&P), dated 5/28/2026, the H&P indicated Resident 59 had the capacity to make decisions. During a review of Resident 59's MDS dated [DATE], the MDS indicated Resident 59 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and mostly needing moderate (helper does less than half the effort) assistance from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff for ADLs. During a concurrent medication observation and interview on 6/10/2026 at 8:36 AM with LVN 2, LVN 2 checked Resident 59's blood pressure without wearing a gown and gloves. LVN 2 stated and validated that Resident 59 needed to be in EBP. LVN 2 also stated that she (LVN 2) was supposed to wear gown and gloves when checking Resident 59's blood pressure. During an interview on 6/10/2026 at 11:55 AM with Registered Nurse 1 (RN 1), RN 1 stated that when checking Resident 59's blood pressure, the nurse was supposed to wear both gown and gloves due to possible risk of infection. During a review of the facility's policy and procedure (P&P), titled, Standard and Enhanced Precautions, reviewed on 12/30/2025, the P&P indicated for residents whom EBP were indicated, EBP should be used when performing high-contact resident care activities. During a review of the facility's P&P titled, Infection Prevention and Control Program reviewed on 12/30/2025, the P&P indicated that the facility established and maintained an infection control program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection in accordance with federal and state requirements.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to maintain the housekeeping standards by failing to:-Ensure a clean and sanitary dumpster area outside the facility's kitchenThis failure had the potential to cause contamination, poor sanitation in the facility and safety risks among its residents and staff. Findings:During a concurrent observation and interview on 6/10/2026 at 8:26 AM with the Maintenance Supervisor, in the dumpster area outside the facility's kitchen, the dumpster area had loose trash present on the ground with significant odor and the concrete pad around the dumpsters was visibly soiled with stains and debris. The Maintenance Supervisor stated that the loose trash should not be sitting on the ground and the area should be kept clean.During an interview on 6/10/2026 at 8:40 AM, with the Infection Preventionist (IP), the IP stated that the facility had an infection control program that included monitoring of adherence to infection prevention standards, with a focus on safety and sanitation practices.During an interview on 6/11/2026 at 10:02 AM with the Maintenance Supervisor and the Housekeeping and Laundry (H&L) Supervisor, the Maintenance Supervisor and the H&L Supervisor stated that the facility had a schedule for housekeeping and sanitation of areas in the facility. The H&L Supervisor stated that housekeeping was very important, especially in areas close to the kitchen, because dirty conditions could potentially affect the health of the residents and staff (in general).During an interview on 6/11/2026 at 10:32 AM, with the Administrator, the Administrator stated the dumpster area outside the kitchen needed sanitation and attention to meet oversight expectations. The Administrator stated that improving the housekeeping process could prevent environmental issues that could potentially harm the residents and staff.During a review of the facility's policy and procedure (P&P) titled, Housekeeping-general, dated 2/9/2024, the P&P indicated that housekeeping ensures the facility is clean, sanitary and in good repair at all times so as to promote the health and safety of residents, staff, and visitors. The Housekeeping Department uses a safe and proper method for cleaning, disinfecting and sterilizing all areas. All infectious wastes are disposed of in a proper and safe manner in accordance with the policies contained in the Infection Control Manual.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility failed to ensure to safeguard the personal belongings for one of two sampled residents (Resident 2) by failing to: -Ensure Resident 2's clothing (in general) was labeled in accordance with the facility's policy and procedure titled Laundry-Resident clothing. This failure resulted in Resident 2's clothing to be unidentifiable, lost, and the potential to negatively affect Resident 2's dignity and right to keep personal property.Findings:During review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 6/24/2022 and readmitted the resident on 1/8/2025 with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), type 2 diabetes mellitus (disorder characterized by difficulty in blood sugar control and poor wound healing), and functional quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 2's History and Physical Examination(H&P) dated 1/6/2026, the H&P indicated Resident 2 had the diagnosis but not limited to dementia (a significant decline in memory, thinking, problem-solving and other cognitive skills that interferes with daily life). During a review of Resident 2's Minimum Data Set (a resident assessment tool) dated 6/3/2026, the MDS indicated Resident 2 could not recall and report correct day of the week. The MDS indicated Resident 2 was dependent (helper does all of the effort) for eating, oral hygiene, toileting, shower, toileting hygiene, lower and upper body dressing. During an interview on 6/9/2026 at 7:55 AM with Resident 2's family member, family member stated that they had brought in some clothing (unidentified) for Resident 2 which the facility was aware of and the items had gone missing.During a concurrent observation and interview on 6/9 /2026 at 10:31 AM with Housekeeping and Laundry (H&L) Supervisor inside the residents' room, Resident 2's closet had some hanging clothing inside and a black, long-sleeve, folded shirt not being labeled. H& L Supervisor stated Resident 2's clothing should be labeled by the facility staff with the resident's name to ensure identification and properly maintained to prevent loss. During an interview on 6/11/2026 at 10:41 AM with Certified Nursing Assistant 1 (CNA1), CNA 1 stated that all residents' clothing should be labeled (in general) with their names and when Resident 2's clothing (unidentified) was missing the Social Services Director was informed about it. During an interview on 6/11/2026 at 10:52 AM with the Social Services Director (SSD), the SSD stated that all staff were trained and informed about labeling the residents' (in general) belongings. The SSD stated that when belongings were lost, it could create emotional distress for families and residents, potentially affecting their overall quality of life and health. During an interview on 6/29/2026 at 10:57 AM with the Director of Nursing (DON), the DON stated that staff were educated to inventory and properly label residents' belongings to avoid frustration to both residents and families. During a review of the facility's policy and procedure (P&P) titled, Laundry-Resident Clothing, dated 2/9/2024, the P&P indicated that laundering of residents' personal clothing includes resident clothing is labeled in accordance with facility procedure and resident clothing should be clearly labeled with the resident's name. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2/9/2024, the P&P indicated that the resident's have the rights to retain and use personal possessions to the maximum extent that space and safety permit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to meet the needs of one of 15 sampled residents (Resident 34) by failing to:- Develop a care plan for Resident 34's breathing treatment (a nebulizer machine that turns liquid medicine into a mist for inhalation).This failure had the potential to result negative impact on Resident 34's health, as well as the quality of care and services received.Findings:During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 4/24/2026 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should).During a review of Resident 34's Order Summary Report, dated 4/24/2026, the Order Summary Report indicated Resident 34 had a physician order for Ipratropium Bromide (breathing treatment medication that stops mucus and opens up airway) 0.02 percent (%) one unit via inhalation (breathing in) every four hours as needed for wheezing (whistling sound or coarse rattle sound when airway is partially blocked during inhalation) or shortness of breath (SOB).During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 34 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to Supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 34's COVID-19 (a respiratory illness that can spread from person to person) vaccine was not up to date.During a concurrent interview and record review on 6/8/2026 at 9:47 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 34's Medication Administration Record (MAR-facility report detailing the drugs administered to a resident by a licensed nurse) was reviewed from 5/1/2026 to 6/8/2026. The MAR indicated Ipratropium Bromide was administered on 5/29/2026 at 8:15 PM.During an interview with Registered Nurse 1 (RN 1) on 6/10/2026 at 10:25 AM, RN 1 stated and validated missing breathing treatment care plan for Resident 34. RN 1 stated the importance of having the breathing treatment care plan so facility could provide individualized care to Resident 34 such as monitoring for any issues such as wheezing, SOB and/or adverse reaction (harmful) after providing breathing treatment to Resident 34.During an interview on 6/11/2026 at 8:34 AM with the Director of Nursing (DON), the DON stated that breathing treatment should be care planned to guide them on how to properly care for Resident 34's respiratory needs.During a review of facility's policy and procedures (P&P) titled Care Planning reviewed on12/30/2025, the P&P indicated that a comprehensive care plan would be developed for each resident including measurable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs. P&P also indicated that each comprehensive care plan will describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, and record review, the facility failed to meet professional standards of care and practice for one of two sampled residents (Resident 37) by failing to ensure diet order was checked prior to serving Resident 37's lunch tray.This failure had the potential to negatively impact on the delivery of care service provided to Resident 37.Findings:During a review of Resident 37's admission Record, the admission Record indicated the facility admitted Resident 37 on 6/9/2024 with diagnoses including hypothyroidism (a condition in which the thyroid gland [a gland that controls hormones in the body] doesn't produce enough thyroid hormone), dysphagia (difficulty swallowing food or liquid), and generalized muscle weakness. During a review of Resident 37's History and Physical (H&P) dated 6/26/2025, the H&P indicated Resident 37 had the capacity to make decisions. During a review of Resident 37's Order Summary Report dated 12/1/2025, the Order Summary Report indicated Resident 37 had a physician order of no added salt level 6 (soft and bite-sized) texture and thin liquids consistency diet.During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 5/13/2026, the MDS indicated Resident 37 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to setup assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).During a concurrent dining observation and interview on 6/8/2026 at 12:17 PM with Registered Nurse 1 (RN 1), the Director of Staff Development (DSD) and Certified Nursing Assistant 2 (CNA 2), observed CNA 2 provided lunch tray to Resident 37. CNA 2 stated that licensed nurses were supposed to check the trays first before handing them to the residents. Both the DSD and RN 1 stated both were supposed to check the food trays using the residents diet order list and comparing it to the tray and the meal prior to serving to the residents. The DSD stated the importance of checking the right diet order to ensure facility was providing the right diet order for the safety of the residents.During an interview on 6/8/2026 at 12:23 PM with the Director of Nursing (DON), the DON stated that it was best practice to check residents' tray with the updated diet list prior to providing meal tray to the residents.During a review of the facility's policy and procedure (P&P), titled, Meal Distribution, reviewed on 12/30/2025, the P&P indicated that nursing staff will be responsible for verifying meal accuracy to residents/patients.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for one of five sampled residents (Resident 34) reviewed for immunizations, by failing to:- Ensure to offer Resident 34 the pneumococcal (Pneumonia [PNA]-infection that inflames air sacs in one or both lungs which may fill with fluid) vaccine, in accordance with facility policy and procedures (P&P) titled Pneumococcal Disease Prevention reviewed by the facility on 12/30/2025 and current standards of practice.This failure placed Resident 34 at a higher risk of acquiring pneumonia as well as other residents, visitors and staff within the facility.Findings:During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 4/24/2026 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should) During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 34 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to Supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). MDS also indicated PNA vaccine was not offered to Resident 34.During an interview on 6/10/2026 at 9:02 AM with Resident 34, Resident 34 stated he (Resident 34) did not remember if the PNA vaccine was offered to him upon admission.During a concurrent interview and record review on 6/11/2026 at 9:40 AM with Registered Nurse 1 (RN 1), Resident 34's immunization record was reviewed via CAIR (California Immunization Registry: secure web-based system that stores immunization records for children and adults in California) as of 6/10/2026. Resident 34's immunization record indicated last PNA vaccine was received on 10/4/2011 with recommendation for a second dose of PNA vaccine. Resident 34's medical record was reviewed, indicated no documentation that PNA vaccine was offered to Resident 34 prior to 6/11/2026. RN 1 stated that the previous infection preventionist nurse (unidentified) resigned and she (RN 1) recently started updating the resident vaccine log. RN1 stated she (RN1) did not have the time to offer the PNA vaccine to Resident 34. RN 1 stated that the facility was supposed to assess and offer PNA vaccine to all residents upon admission. RN 1 stated the importance of offering PNA vaccine since Resident 34 recently had PNA infection and was at risk for respiratory infection.During a review of facility's P&P, titled, Pneumococcal Disease Prevention reviewed by the facility on 12/30/2025, the P&P indicated that facility would provide education and offer the PNA vaccine to residents to prevent and control the spread of PNA disease in the facility.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for one of five sampled residents (Resident 34) reviewed for immunizations, by failing to:-Ensure to offer Resident 34 the COVID-19 (Coronavirus- a deadly respiratory disease transmitted from person to person) vaccine, in accordance with facility policy and procedures (P&P) titled COVID-19 Vaccination reviewed by the facility on 12/30/2025 and current standards of practice.This failure placed Resident 34 at a higher risk of acquiring COVID-19 as well as other residents, visitors, and staff within the facility.Findings:During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 4/24/2026 with diagnoses including chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe), pneumonia (PNA-infection that inflames air sacs in one or both lungs which may fill with fluid) and congestive heart failure (CHF-a chronic condition in which the heart does not pump blood as well as it should).During a review of Resident 34's Minimum Data Set (MDS- a resident assessment tool), dated 4/30/2026, the MDS indicated Resident 34 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and from moderate (helper does less than half the effort) to Supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). MDS also indicated Resident 34's COVID-19 vaccine was not up to date.During an interview on 6/10/2026 at 9:02 AM with Resident 34, Resident 34 stated he (Resident 34) did not remember if the COVID-19 vaccine was offered to him upon admission.During a concurrent interview and record review on 6/11/2026 at 9:40 AM with Registered Nurse 1 (RN 1), Resident 34's immunization record was reviewed via CAIR (California Immunization Registry: secure web-based system that stores immunization records for children and adults in California) as of 6/10/2026. Resident 34's immunization record indicated last COVID-19 vaccine was received on 7/12/2024 with recommendation for a seasonal dose of COVID-19 vaccine. Resident 34's medical record was reviewed, indicated no documentation that COVID-19 vaccine was offered to Resident 34 prior to 6/11/2026. RN 1 stated that the previous infection preventionist nurse (unidentified) resigned and she (RN 1) recently started updating the resident vaccine log. RN1 stated she (RN1) did not have time to offer the COVID-19 vaccine to Resident 34. RN 1 stated that the facility was supposed to assess and offer COVID-19 vaccine to all residents upon admission. RN 1 stated importance of offering COVID-19 vaccine since Resident 34 was at risk for respiratory infection.During a review of facility's P&P, titled, COVID-19 Vaccination reviewed by the facility on 12/30/2025, the P&P indicated that facility would provide education and offer the COVID-19 vaccinations to residents to reduce transmission of COVID-19.