STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056113	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alexandria Care Center	1515 N Alexandria Ave. Los Angeles, CA 90027

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 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. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) by:Failing to develop a care plan on legionnaires disease (a severe form of a lung infection called pneumonia caused by a bacterium known as legionella) when Resident 1 had presumptive positive (a test administered by local health professionals is positive) legionella (naturally found in [NAME], but becomes a health risk when they grow in man-made water systems and the contaminated water is aerosolized - tiny particles suspended in the air, leading to inhalation and causing lung illness) upon return to the facility on [DATE].Failing to develop a care plan on Resident 1's use of azithromycin (medication used to treat infection) when Resident 1 had azithromycin on 11/30/2025.These failures had potential for delay in the delivery of necessary care and services to Resident 1.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/20/2021, with diagnoses that included hereditary (something passed down from one generation to the next) and idiopathic (a disease or condition arises from an unknown or spontaneous cause) neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and history of falling.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 8/9/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/9/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate assistance from staff for oral hygiene, toileting and personal hygiene.During a review of Resident 1's Discharge to Skilled Nursing Facility Summary and Transfer Orders, dated 11/29/2025, the Discharge to Skilled Nursing Facility Summary and Transfer Orders indicated Resident 1 had multifactorial (involving or dependent on a number of factors or causes) pneumonia (an infection/inflammation in the lungs) due to rhinovirus (the main germ that causes the common cold) and legionnaires disease with an order for azithromycin daily by mouth 250 milligram (mg- mg- metric unit of measurement, used for medication dosage and/or amount) for legionella pneumonia.During a concurrent interview, and record review on 12/24/2025, at 8:39 a.m., with Registered Nurse 1 (RN 1), Resident 1's care plans were reviewed. RN 1 stated Resident 1's care plan for legionella was developed on 12/3/2025.b. During a review of Resident 1's Order Summary Report, dated 11/29/2025, the Order Summary indicated azithromycin oral tablet 250 mg, give one tablet by mouth one time a day for pneumonia for three days.During a review of Resident 1's Medication Administration Record (MAR-flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated Resident 1 received azithromycin on 11/30/2025.During a review of Resident 1's MAR, dated 12/2025, the MAR indicated Resident 1 received azithromycin on 12/1/2025 and 12/2/2025.During a concurrent interview, and record review on 12/24/2025, at 8:39 a.m., with RN 1, Resident 1's care plans were reviewed. RN 1 stated Resident 1 was on azithromycin from 11/29/2025 to 12/2/2025. RN 1 stated care plan for azithromycin was not developed until 12/3/2025. RN 1 stated care plan informs the nurses on what intervention to perform to achieve resident's goals.During an interview on 12/24/2025, at 9:12 a.m., with the Director of Nursing (DON), the DON stated the facility was late in developing the care plan for use of antibiotic azithromycin and legionnaires disease. The DON stated the care plans for use of antibiotic azithromycin and legionnaires disease should have been developed on 11/29/2025. The DON stated care plan guides the nurses on what to do to address Resident 1's problems. The DON stated not timely development of a care plan could possibly result in nurses not performing the interventions to provide care to Resident 1.During an interview on 12/24/2025 at 1:20 p.m., with the Infection Preventionist (IP), the IP stated care plans help nurses care for the residents. The IP stated delay in developing care plans could potentially delay Resident 1's care.During a review of facility's policy and procedures (P&P), titled, Care Plan Comprehensive, dated 8/25/2021,and last reviewed on 1/22/2025, the P&P indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial (interrelation of social factors and individual thought and behavior) needs shall be developed for each resident.Each resident ' s comprehensive care plan is designed to:a. Incorporate

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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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to clarify the physician's order for one of three sampled residents (Resident 1) by failing to:1. Ensure licensed nurses clarify the two physician orders of famotidine (medication used to decrease amount of acid in the stomach). On 11/1/2025 to 11/4/2025, Resident 1 received two doses of famotidine at 6:30 a.m., and at 9 a.m. 2. Ensure licensed nurses follow the physician order to administer guaifenesin (medication used to treat chest congestion) and dextromethorphan (medication used to treat cough)- guaifenesin medication every six hours as needed. On 11/20/2025, Resident 1 received the two medications with only three hours in between.These failures had the potential to result in Resident 1 experiencing side effects (any unintended response to a medicine or treatment that happens in addition to its main purpose) like nausea, vomiting, drowsiness (feeling unusually sleepy) and/or low blood pressure.Findings:During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 5/20/2021, with diagnoses that included hereditary (something passed down from one generation to the next) and idiopathic (a disease or condition arises from an unknown or spontaneous cause) neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and history of falling.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 8/9/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Physician Order, dated 12/15/2023, the Physician Order indicated famotidine oral tablet 40 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth one time a day for gastroesophageal reflux disease (GERD-when stomach acid repeatedly flows back up into the food pipe, causing irritation and symptoms like heartburn [that painful burning feeling in your chest]).During a review of Resident 1's Order Summary Report, dated 9/20/2025, the Order Summary Report indicated famotidine oral tablet 40 mg, give one tablet by mouth in the morning for GERD, 30 minutes before breakfast.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/9/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate assistance from staff for oral hygiene, toileting and personal hygiene.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated Resident 1 received famotidine on 11/1/2025 to 11/4/2025 at 6:30 a.m., and at 9 a.m. During a concurrent interview, and record review on 12/24/2025, at 7:45 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1's Physician Orders, and MAR, dated 11/2025, were reviewed. LVN 1 stated there were two orders of famotidine, one for daily and another before breakfast. LVN 1 stated orders for famotidine should have been clarified.During an interview on 12/24/2025, at 8:29 a.m., with the Director of Staff Development (DSD), the DSD stated the famotidine order should have been clarified with the physician. The DSD stated it was a medication error and Resident 1 received double doses of the famotidine.b. During a review of Resident 1's Physician Order, dated 4/30/2025, the Physician Order indicated guaifenesin oral liquid 100 mg/milliliter (ml-unit of measurement), give 10 ml by mouth every six hours as needed for productive cough.During a review of Resident 1's Physician Order, dated 11/19/2025, the Physician Order indicated dextromethorphan-guaifenesin 10-100 mg/5 ml, give 10 ml by mouth every six hours as needed for cough.During a review of Resident 1's MAR, dated 11/2025, the MAR indicated Resident 1 received guaifenesin on 11/20/2025 at 4:56 a.m.During a review of Resident 1's MAR, dated 11/2025, the MAR indicated Resident 1 received dextromethorphan-guaifenesin on 11/20/2025 at 8 a.m.During a concurrent interview, and record review on 12/24/2025, at 7:45 a.m., with LVN 1, Resident 1's Physician Orders, and MAR, dated 11/2025 were reviewed. LVN 1 stated guaifenesin and dextromethorphan- guaifenesin were the same medication. LVN 1 stated the order was to be given every six hours. LVN 1 stated on 11/20/2025, Resident 1 received guaifenesin at 4:56 a.m. and Resident 1 received dextromethorphan- guaifenesin at 8 a.m. LVN 1 stated that it was only three hours and not six hours in between the two medications. LVN 1 stated Resident 1 could experience overdose (taking too much of a substance such as medicine) of the cough medicine.During an interview on 12/24/2025, at 8:29 a.m., with the DSD, the DSD stated guaifenesin and dextromethorphan- guaifenesin were the same. The DSD stated the nurses did not clarify and did not follow the order. The DSD stated Resident 1 could have upset stomach During an interview on 12/24/2025, at 8:39

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical record for one of three sampled residents (Resident 1) by failing to accurately document oxygen device used by Resident 1 on [DATE].This failure had the potential to result in confusion in care and the medical records containing inaccurate documentation.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on [DATE], with diagnoses that included hereditary (something passed down from one generation to the next) and idiopathic (a disease or condition arises from an unknown or spontaneous cause) neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and history of falling.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated [DATE], the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated [DATE], the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate assistance from staff for oral hygiene, toileting and personal hygiene.During a review of Resident 1's eInteract Change in Condition Evaluation (CIC-document used to record and report any significant changes in a resident's physical, mental, or psychosocial status), dated [DATE], the CIC indicated on [DATE], at 4:50 p.m., Resident 1 had desaturation (low oxygen blood level) and chest congestion (a buildup of excess mucus and fluid in the airways and lungs, making it hard to breathe). The CIC indicated Resident 1 had low oxygen saturation (blood oxygen level) and Resident 1 received 15 liters of oxygen using face mask (device that offers moderate oxygen 50-60 percent [%] with air holes, allowing some rebreathing and room air, suitable for less severe needs). The CIC indicated at 5 p. m., Resident 1 became unresponsive with no pulse. The CIC indicated cardiopulmonary resuscitation (CPR-an emergency procedure combining chest compressions and rescue breaths to maintain blood flow and oxygen to the brain and organs when someone's heart stops) started and paramedics (a person trained to give emergency medical care to people who are injured or ill) continued CPR at 5:12 p.m.During a review of Resident 1's Progress Notes, dated [DATE], timed at 7:54 p.m., the Progress Notes indicated Registered Nurse 3 (RN 3), documented on [DATE], at 4:50 p.m., Resident 1 had chest congestion, with 87% oxygen saturation. The Progress Notes indicated 15 liters of oxygen were administered via face mask. The Progress Notes indicated Resident 1 became unresponsive at 5 p.m., CPR started, paramedics were called and took over at 5:12 p.m. and at 5:25 pm Resident 1 had a pulse and was transferred to general acute care hospital (GACH).During a concurrent interview, and record review on [DATE], at 7:45 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 1's CIC dated [DATE], was reviewed. LVN 1 stated the maximum amount of oxygen that can be given through a face mask was six liters.During an interview on [DATE], at 8:29 a.m., with the Director of Staff Development (DSD), the DSD stated the maximum amount of oxygen that can be administered using a face mask was six liters and 15 liters for non-rebreather mask (device used to deliver very high oxygen concentrations up to 90% with one-way valves preventing rebreathing exhaled air and room air, ideal for severe hypoxia [low oxygen]).During an interview on [DATE], at 2:26 p.m., with RN 3, RN 3 stated on [DATE], when Resident 1 had desaturated, she (RN 3) had used the non-rebreathing mask to deliver 15 liters of oxygen and saturation still low at 88% to 90%. RN 3 stated she (RN 3) had documented incorrectly.During an interview on [DATE], at 1:00 p.m., with the Director of Nursing (DON), the DON stated it is important to document accurately in Resident 1's medical record to show what was the intervention provided to the resident when resident had low oxygen saturation. The DON stated using face mask with 15 liters of oxygen will not be effective in delivering oxygen and could potentially cause continued low saturation. During a review of facility's policy and procedure (P&P), titled, Nursing Documentation, dated [DATE], and last reviewed on [DATE], the P&P indicated, To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. Nursing documentation will follow the guidelines of good communication and be concise, clear, pertinent, and accurate based on the resident's/patient's condition, situation, and complexity. Documentation includes information about the patient's status, nursing assessment and interventions, expected outcomes, evaluation of the patients' outcomes, and responses to nursing care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its infection control measures for two of three sampled residents (Residents 2 and 6) who were on enhanced barrier precaution (EBP- wearing a protective gown and gloves whenever you are doing close-contact care with a patient who might be carrying these germs) by failing to:a. Ensure Registered Nurse 4 (RN 4) wore a mask, gloves, and gown before disconnecting and flushing (pushing fluid through an intravenous [IV-within a vein]) Resident 2's IV line. b. Ensure Licensed Vocational Nurse 2 (LVN 2) wore a mask, gloves, and gown at Resident 2's bedside. c. Ensure LVN 3 wore a gown at Resident 3's bedside while providing gastrostomy tube (gtube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) care.These failures had the potential for cross contamination (unintentional transfer of bacteria or germs or other contaminants from one surface to another) and spread of infection among staff and other residents.Findings:During a review of Resident 2's admission Record, the admission Record indicated the facility admitted Resident 2 on 12/15/2025, with diagnoses that included right ankle and foot other acute osteomyelitis (inflammation of bone or bone marrow, usually due to infection), dysphagia (difficulty swallowing) and non-pressure chronic ulcer (a persistent skin wound lasting over two to six weeks not caused by prolonged pressure, often resulting from poor circulation) of right ankle.During a review of Resident 2's Care Plan, dated 12/16/2025, the Care Plan indicated Resident 2 was on EBP related to wounds with the following interventions:Direct care staff and visitors to follow EBP,Direct care staff to utilize gowns and gloves for all personal care. During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool) dated 12/20/2025, the MDS indicated Resident 2's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired.During an observation on 12/23/2025, at 7:32 a.m., outside of Resident 2's room, an EBP signage observed outside of Resident 2's door. Observed an isolation (separation of residents with an infection from residents without an infection) container with yellow disposable gowns, gloves and mask hanging on Resident 2's door. Observed LVN 2 standing on the right side of Resident 2's bed leaning forward with no mask and not wearing a gown.During an observation on 12/23/2025, at 7:33 a.m., outside of Resident 2's room, Registered Nurse 4 (RN 4) went inside Resident 2's room without a mask, gloves, and gown. RN 4 stood on the left side of Resident 2's bed, disconnected the IV tubing from the IV and flushed the IV.During an observation on 12/23/2025, at 7:34 a.m., outside of Resident 2's room, LVN 2 went inside Resident 2's room with no gloves, no mask, and no gown.During an interview on 12/23/20025, at 7:35 a.m., with RN 4, RN 4 stated, a mask should be worn at all times while inside the facility. RN 4 stated he (RN 4) went inside Resident 2's room because LVN 2 called him (RN 4) and he (RN 4) disconnected and flushed the IV. RN 4 stated he (RN 4) should have used mask, gloves and gown when he (RN 4) flushed Resident 2's IV. RN 4 stated he (RN 4) did not wear a gown because he (RN 4) just came inside the room to help LVN 2. RN 4 stated Resident 2 threw up reason why LVN 2 was at the bedside.During an interview on 12/23/2025, at 7:41 a.m., with LVN 2, LVN 2 stated Resident 2 was on EBP due to the IV. LVN 2 stated she (LVN 2) was at Resident 2's bedside checking the blood pressure because Resident 2 had thrown up coffee ground emesis. LVN 2 stated she (LVN 2) forgot to wear a mask. LVN 2 stated she (LVN 2) did not see the supply of masks available by Resident 2's door. LVN 2 stated she (LVN 2) should have worn a mask, gloves and gown before checking Resident 2's blood pressure because Resident 2 might throw up again.During an interview on 12/23/2025, at 7:46 a.m., with RN 1, RN 1 stated Resident 2 was on EBP due to midline catheter (long, thin, flexible tube inserted into a peripheral vein in the upper arm, with its tip ending near the armpit, providing longer-term IV access than standard IVs). RN 1 stated when disconnecting IV, staff need to wear gloves and gowns with mask. RN 1 stated it was influenza (flu-a contagious [spreads easily from one person to another] respiratory infection caused by a virus that attacks your nose, throat, and lungs, leading to fever, aches, cough, and fatigue) season and staff are required to wear a mask in the facility to prevent spread of flu. RN 1 stated gown should be worn when handling midline catheter because the catheter might be pulled out and blood can contaminate staff clothes, and gown prevent contamination. RN 1 stated staff who did not wear the personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) like mask, gown and gloves can expose Resident 2 to viruses and contract (acquire) infection.During an interview on 12/23/2025, at 8:02 a.m., with the Director of

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) program and infection prevention and control program for one of three sampled residents (Resident 1) by failing to monitor Resident 1 for the use and adverse effects (undesired or harmful effects) of azithromycin (antibiotic medication used to treat infection) on 11/29/2025 to 12/2/2025.This failure had the potential to increase antibiotic resistance (do not respond to a drug) from unnecessary or inappropriate antibiotic use and had the potential for Resident 1 to experience an adverse reaction.Findings:During a review of Resident 1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 5/20/2021, with diagnoses that included hereditary (something passed down from one generation to the next) and idiopathic (a disease or condition arises from an unknown or spontaneous cause) neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), and history of falling.During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 8/9/2023, the H&P indicated Resident 1 did not have the capacity to understand and make decisions.During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool), dated 11/9/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 required moderate assistance from staff for oral hygiene, toileting and personal hygiene.During a review of Resident 1's Order Summary Report, dated 11/29/2025, the Order Summary indicated azithromycin oral tablet 250 milligram (mg- mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth one time a day for pneumonia (an infection/inflammation in the lungs) for three days.During a review of Resident 1's Medication Administration Record (MAR-flowsheet that indicates medications given to a resident), dated 11/2025, the MAR indicated Resident 1 received azithromycin on 11/30/2025.During a review of Resident 1's MAR, dated 12/2025, the MAR indicated Resident 1 received azithromycin on 12/1/2025 and 12/2/2025.During a review of Resident 1's Progress Notes, dated 11/30/2025 to 12/2/2025, the Progress Notes did not indicate antibiotic monitoring. During a concurrent interview and record review on 12/24/2025, at 1:20 p.m., with the Infection Preventionist (IP), Resident 1's Order Summary Report, dated 11/29/2025, MAR and Progress Notes, dated 11/30/2025 to 12/2/2025 were reviewed. The IP stated nurses monitor residents on antibiotics for its side effects (undesirable effect of a drug or medical treatment) every shift. The IP stated there was no documented antibiotic monitoring in Resident 1's Progress Notes from 11/30/2025 to 12/2/2025. The IP stated staff should have monitored Resident 1 for the side effects of azithromycin. The IP stated the importance of monitoring residents on antibiotics was to make sure residents do not have an adverse reaction or side effects from the medication. The IP stated Resident 1 who was not monitored for antibiotic use and side effects could have side effects or adverse reaction that can lead to complication (a new or worsening medical problem that arises during a disease, treatment, or procedure) and could lead to a delay in care and delay in treatment. During an interview on 12/30/2025, at 1 p.m., with the Direcor of Nursing (DON), the DON stated nurses should monitor Resident 1 for the side effects and use of azithromycin every shift. The DON stated if Resident 1 was not monitored, nurses would not know if there were side effects and could possibly lead to delay in physician notification and delay in care.During a review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program dated 9/18/2024, and last reviewed on 1/22/2025, the P&P indicated, Antibiotic StewardshipCulture reports (identifies microorganisms causing an infection), sensitivity (the ability of a test to correctly identify patients with a disease) data, and antibiotic usage reviews are included in surveillance activities.Medical criteria and standardized definitions of infections are used to help recognize and manage infections.Antibiotic usage is evaluated, and practitioners are provided feedback on reviews.11. Prevention of Infection. (2) instituting measures to avoid complications or dissemination.During a review of facility's P&P, titled, Antibiotic Stewardship-Review and Surveillance of Antibiotic Use and Outcomes, dated 9/18/2023, and last reviewed on 1/22/2025, indicated, Antibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and