STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056206	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
University Park Healthcare Center	230 E Adams Blvd Los Angeles, CA 90011

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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	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to accurately account for four doses of controlled medications (medications with a high risk for abuse or diversion [any use other than that intended by the prescriber]) affecting Resident 18, Resident 29, and Resident 61 in one of two inspected medication carts (Medication Cart 1). This deficient practice increased the risk of diversion (illegal transfer/use) of controlled medications and the risk that Resident 18, Resident 29, and Resident 61 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization.Findings: During an observation and concurrent interview of Medication Cart 1 on 4/1/2026 at 11:11 AM with Licensed Vocational Nurse 2 (LVN 2) the following discrepancies were found between the Narcotic and Hypnotic Record (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the medication): -Resident 18's Narcotic and Hypnotic Record for lorazepam (a medication used to treat mental illness) 0.5 milligrams (mg - a unit of measure for mass) indicated there were 25 doses left; however, the medication card contained 24 doses. -Resident 29's Narcotic and Hypnotic Record for clonazepam (a medication used to treat mental illness) 0.5 mg indicated there were 19 doses left; however, the medication card contained 18 doses. -Resident 29's Narcotic and Hypnotic Record for phenobarbital (a medication used to treat seizures) 64.8 mg indicated there were 25 doses left; however, the medication card contained 24 doses. -Resident 61's Narcotic and Hypnotic Record for hydrocodone/apap (a medication used to treat pain) 5/325 mg indicated there were 50 doses left; however, the medication card contained 49 doses. During a concurrent interview on 4/1/2026 at 11:11 AM with LVN 2, LVN 2 stated she (LVN2) administered all of the missing controlled medications for Resident 18, Resident 29 and Resident 61 on 4/1/2026 but failed to sign the corresponding Narcotic and Hypnotic Records because she (LVN2) was distracted by other tasks. LVN 2 stated she (LVN2) was required to sign the Narcotic and Hypnotic Record immediately after the dose was administered. LVN 2 stated that ensured accountability of the controlled medications was maintained and helped to prevent medications from being administered too often to residents (in general) which could lead to medical complications. A review of the facility's policy Controlled Substances, revised April 2019, indicated Upon administration, the nurse administering the medication is responsible for recording. time of administration. quantity of the medication remaining; and signature of nurse administering medications.

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Five errors out of 27 opportunities contributed to an overall error rate of 18.52 % affecting three of four residents observed for medication administration (Resident 17, Resident 20, and Resident 98). The errors noted were as follows: a. Incorrect drug (senna/docusate - a medication used to stimulate a bowel movement) administered to Resident 98. b. Incorrect drug (senna/docusate) administered to Resident 17.-Failure to administer metformin (a medication used to treat high blood sugar) with food per the physician order for Resident 17. c. Incorrect formulation of multivitamins (multivitamins with minerals - a supplement) administered to Resident 20.-Incorrect strength of lidocaine patch (a medication used to treat pain) administered to Resident 20. The deficient practice of failing to administer medications in accordance with the physician's orders or professional standards increased the risk that Resident 17, Resident 20, and Resident 98 could experience medical complications possibly resulting in hospitalization.Findings: a. During an observation of medication administration on 4/1/2026 at 8:04 AM with Licensed Vocational Nurse 2 (LVN 2), LVN 2 was observed preparing the following medication for Resident 98:-One tablet of senna/docusate 8.6/50 milligrams (mg - a unit of measure for mass). During an observation on 4/1/2026 at 8:08 AM, Resident 98 was observed taking the senna/docusate tablet along with other medications by mouth with water. During a review of Resident 98's admission Record dated 4/2/2026, the admission Record indicated the facility admitted Resident 98 on 5/26/2024 and most recently readmitted on [DATE] with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (right-side weakness and paralysis following a stroke.) During a review of Resident 98's History and Physical (H&P, a record of a physician's comprehensive medical assessment) dated 3/14/2026, the H&P indicated Resident 98 had the capacity to understand and make medical decisions. During a review of Resident 98's Order Summary Report (a monthly summary report of all active physician orders) dated 3/30/2026, the Order Summary Report indicated Resident 98's attending physician prescribed the following: -Senna 8.6 mg tablet by mouth two times daily for constipation During an interview on 4/1/2026 at 8:45 AM with LVN 2, LVN 2 stated she (LVN2) administered the incorrect formulation of senna to Resident 98. LVN 2 stated she (LVN2) administered a combination product containing both senna and docusate rather than the senna alone as indicated on the physician's order. LVN 2 stated she (LVN2) failed to check the label of the product against the physician's order prior to administering the medication. LVN 2 stated failing to ensure she (LVN2) was administering the right medication to the resident could result in major health complications possibly resulting in hospitalization. b. During an observation of medication administration on 4/1/2026 at 8:26 AM with LVN 2, LVN 2 was observed preparing the following medications for Resident 17:-One tablet of senna/docusate 8.6/50 mg.-One tablet of metformin 1000 mg. During an observation on 4/1/2026 at 8:40 AM, Resident 17 was observed taking the metformin tablet by mouth with water along with other medications and refusing the senna/docusate tablet. During a review of Resident 17's admission Record dated 4/2/26, the admission Record indicated the facility admitted Resident 17 on 2/14/2026 with diagnoses including type 2 diabetes (a medical condition characterized by poor blood sugar control). During a review of Resident 17's H&P dated 2/17/2026, the H&P indicated Resident 17 had the capacity to understand and make medical decisions. During a review of Resident 17's Order Summary Report dated 3/30/26, the Order Summary Report indicated Resident 98's attending physician prescribed the following: -Senna 8.6 mg to give two tablets by mouth two times a day for bowel management.-Metformin 1000 mg by mouth two times a day at 7:15 AM and 5:00 PM with meals. During an interview on 4/1/2026 at 8:45 AM with LVN 2, LVN 2 stated she (LVN2) administered the incorrect formulation of senna to Resident 17. LVN 2 stated she (LVN2) administered a combination product containing both senna and docusate rather (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than the senna alone as indicated on the physician's order. LVN 2 stated she (LVN2) failed to check the label of the product against the physician's order prior to administering the medication. LVN 2 stated failing to ensure she (LVN2) was administering the right medication to the resident could result in major health complications possibly resulting in hospitalization. During an interview on 4/1/2026 at 10:15 AM with LVN 2, LVN 2 stated she (LVN2) failed to administer Resident 17's metformin with a meal as required by the physician order. LVN 2 stated most residents (in general) usually completed their breakfast between 7AM and 8AM, but she (LVN2) did not know exactly when Resident 17 completed her (Resident 17) breakfast. LVN 2 stated the metformin was not given to Resident 17 with her breakfast and it was also given at the wrong time as it was scheduled for 7:15 AM and given around 8:40 AM. LVN 2 stated this may cause Resident 17 to have an upset stomach, possibly leading to a decline in her quality of life. c. During an observation of medication administration on 4/1/2026 at 8:51 AM with LVN 3, LVN 3 was observed preparing the following medication for Resident 20:-One tablet of multivitamins w/ minerals.-One lidocaine 5% patch. During an observation on 4/1/2026 at 9 AM, Resident 20 was observed taking the multivitamin with minerals tablet by mouth with water and LVN 3 was observed applying the lidocaine 5% patch to the middle of Resident 20's upper back. During a review of Resident 20's admission Record dated 4/2/26, the admission Record indicated the facility admitted Resident 20 on 2/25/2026 with diagnoses including spondylosis without myelopathy or radiculopathy, cervical region (an age-related degeneration of the spine's vertebrae, discs, and joints often causing stiffness and pain in the upper back/neck region). During a review of Resident 20's H&P dated 2/27/2026, the H&P indicated Resident 20 did not have the capacity to understand and make medical decisions. During a review of Resident 20's Order Summary Report dated 3/30/2026, the Order Summary Report indicated Resident 20's attending physician prescribed the following: -Lidocaine 1.8 % patch to apply topically to skin one time a day for arthritis (the inflammation of one or more joints, causing pain, swelling, stiffness, and reduced mobility) pain.-One multivitamin tablet (formulation without minerals) by mouth one time a day for supplement. During an interview on 4/1/2026 at 10:22 AM with LVN 3, LVN 3 stated he (LVN3) administered the wrong formulation of multivitamins to Resident 20. LVN 3 stated he (LVN3) administered the formulation with minerals whereas the order specifies the version without. LVN 3 stated he (LVN3) also administered the wrong dose of lidocaine patches to Resident 20. LVN 3 stated Resident 20's order for lidocaine patch was 1.8 % and he (LVN3) administered a 5 % patch. LVN 3 stated the lidocaine 5 % patch was a prescription product, and he (LVN3) accidentally administered it from a different resident's (unidentified) supply. LVN 3 stated he (LVN3) failed to check the prescription label before obtaining the lidocaine patch. LVN 3 stated he (LVN3) also failed to check the strength of the lidocaine patch versus Resident 20's order. LVN 3 stated he (LVN3) failed to check the formulation of the multivitamins versus Resident 20's order. LVN 3 stated administering the wrong formulation, wrong strength, or wrong resident's medications could cause medical complications which could possibly be life threatening. During a review the facility's policy Administering Medications, revised April 2019, indicated Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medications. Medications ordered for a particular resident may not be administered to another resident.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure to follow the standardized (consistent) recipes for lunch menu on 3/31/2026 by failing to: 1.Ensure 14 residents (unidentified) on pureed diet (foods that do not require chewing and are easily swallowed and should be smooth and pureed to the consistency of pudding) received bread texture in a form that met their needs and in accordance with the international Dysphagia Diet Initiative (IDDSI- a framework made up of levels and describes food textures and drink thickness) Level Four (pureed foods and extremely thick drinks) when the texture of the pureed bread was lumpy, dry, not smooth and had small pieces of bread crust present requiring chewing before swallowing. 2.Follow food production recipes for the renal (related to the kidneys) diet. Two residents (unidentified) on renal diet received chicken nuggets and rice instead of turkey patty with gravy and pasta with margarine per menu. These deficient practices had the potential to result in meal dissatisfaction, decreased nutritional intake, and increased choking risk for the residents (unidentified) on the pureed diet. Findings: During an observation of the tray line (tray line- a system of food preparation, in which trays move along an assembly line) service for lunch on 3/31/2026 at 12:06 PM the pureed bread looked lumpy, dry, and not smooth while in a pan on the steam table (a table with slots to hold food containers which are kept hot by steam circulating beneath them). During a concurrent observation and interview with [NAME] on 3/31/2026 at 12:10PM, Cook1 stated the pureed bread was made with blended whole wheat bread. During a concurrent interview and taste test (sampling the flavor and texture of the prepared meal) of the pureed bread on 3/31/2026 at 12:45PM with the Dietary Supervisor (DS) the pureed bread was grainy, dry, and not smooth requiring chewing before swallowing. The pureed bread was stuck to the spoon and during tasting it was stuck on the roof of the mouth and not easy to swallow. During the same taste test on 3/31/2026 at 12:45PM, the DS stated the bread was not smooth, was chewy, and sticky. The DS stated the pureed bread needed to be blended longer and should be moist. The DS stated when the pureed texture was not prepared right it could be a risk for choking for the residents (unidentified) who were on a pureed diet. During an interview on 3/31/2026 at 12:45PM with the Registered Dietitian (RD), the RD stated the pureed bread was not smooth because the cook (unidentified) used a whole wheat bread to make it. The RD stated the pureed bread is grainy and requires some chewing. The RD stated puree texture should not need chewing and must be smooth. During an interview on 3/31/2026 at 1PM with Cook1, Cook1 stated the pureed bread was not smooth and was lumpy because [NAME] 1 used whole wheat bread. [NAME] 1 stated [NAME] 1 should have blended the bread longer and added more liquid to make it smoother. Puree texture that was not smooth could cause problems with residents (in general) who have difficulty chewing and swallowing. During a review of the facility recipe titled Pureed (IDDSI Level 4)Breads, cakes, cookies, pancakes and other bread products (dated 2025) the recipe indicated, puree bread on low speed adding milk gradually.the finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and Fork drip test. 2.During a review of the facility lunch menu on 3/31/2026 indicated that the following items would be served for the Renal Diet (a diet aimed at keeping levels of fluids, electrolytes, and minerals balanced in the body in individuals with kidney disease or dialysis):-Turkey Pattie with gravy three ounces (oz); wheat pasta with margarine 1/2 cup; Italian green beans 1/2 cup; 1 slice of garlic bread; sugar cookies; beverage. During an observation on 3/31/2026 at 12:06PM of the tray line service for lunch residents (unidentified) who were on renal diet the cook (Cook1) served chicken nuggets (a small piece of chicken meat-either minced or whole muscle-that is breaded or battered, (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	then deep-fried or baked and is often a frozen food item) and white rice instead of the items on the menu. During an interview on 3/31/2026 at 1PM with Cook1, Cook1 stated they (unidentified kitchen staff) served chicken nuggets because they did not have turkey Pattie and chose chicken nuggets because most residents (unidentified) preferred them as an alternative to the regular menu. Cook1 stated he (Cook1) forgot that whole wheat pasta was on the menu. Cook1 stated he (Cook1) made a mistake and did not follow the menu to prepare the items for renal diet. Cook1 stated he (Cook1) did not inform the DS or the RD when the ingredients were missing and was substituting chicken nuggets and rice for the turkey patties and whole wheat pasta. During a concurrent interview on 3/31/2026 at 1 PM with the DS and the RD, the DS stated they had ground turkey meat and cooks (in general) could follow the recipe to prepare turkey patty as indicated on the menu. The RD stated staff (kitchen staff in general) should inform the RD and the DS when ingredients were missing to make proper adjustment on the menu to serve similar foods keeping in mind the preference for residents who were on a renal diet. The DS stated renal diet was ordered by doctors and it was important to follow to make sure the right food was served to residents on this diet. The DS stated when residents did not get what was on the menu they (residents) could get upset and refuse to eat. During a review of the facility's cooks spreadsheet titled Spring Menus (page 2) for week1 Tuesday (dated 3/31/2026), the spreadsheet indicated to serve Renal diets: Turkey patty with gravy; wheat pasta with margarine; Italian green beans, garlic bread; dessert and beverage During a review of facility's Policy and Procedure (P & P) titled Therapeutic and Liberalized Diet policy (revised 1/15/2026) the p & p indicated, therapeutic diets shall be provided when indicated based on physician orders, clinical condition and interdisciplinary team recommendations. Liberalized Diet Policy- the facility supports least restrictive diets to enhance quality of life and promote intake, Registered Dietitian will evaluate need for liberalization, resident preference will be considered. During a review of facility policy and procedures (p & p) titled, Menu Planning (dated 2023), the p & p indicated, The menus are planned to meet nutritional needs of residents in accordance with established national guidelines.Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure safe and sanitary food storage practices in the kitchen when: 1.One scoop was stored inside bulk rice container, and the handle was in contact with the food. 2.Bulk food (flour, rice, oatmeal) was stored inside trash bags that were not food grade (refers to materials that are safe for direct contact with food, free from harmful substances, and designed to prevent contamination). These deficient practices had the potential to result in cross contamination of food (transfer of harmful bacteria and chemicals from one place to another) that could lead to foodborne illness (food poisoning) in 79 out of 81 residents (unidentified) who received food from the facility.Findings:1. During an observation on 3/31/2026 at 9 AM inside the kitchen, one of the bulk dry food storage bins containing rice, the scoop was stored on the food, and the handle of the scoop was touching the rice. During a concurrent observation and interview on 3/31/2026 at 9 AM with the Dietary Supervisor (DS), the DS stated the scoop should not be inside the bin and on the food because the handle was not clean and could contaminate the food. The DS stated all the scoops were hanging on a holder inside the bins. During a review of the 2022 U.S. Food and Drug Administration Food Code titled In-Use utensils, Between-Use Storage Code 3-304.12 indicated, During pauses in Food operation or dispensing, Food preparation and dispensing utensils shall be stored: (E) In food that is not time/temperature control for safety food with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, flour or cinnamon. 2.During an observation on 3/31/2026 at 9 AM inside the kitchen, bulk food (oatmeal, rice and flour) was stored in large bins that were lined with plastic bags. During a concurrent observation and interview on 3/31/2026 at 9 AM with the DS, the DS stated the plastic liners inside the bins were regular trash bags and were not food grade. The DS stated the kitchen staff (in general) used the same bags for trash, and they were stored in the chemical room. The DS stated he (DS) would remove the bulk food and store it directly inside the plastic bins that were easy to clean and sanitize after use. The DS stated plastic trash bags could cause chemical contamination of food. During a review of facility's policy and procedures (p & p) titled Storage of Food and Supplies (dated 2023), the p & p indicted, Dry bulk foods (flour, sugar, dry beans, food thickener, spices, etc.)should be stored in seamless metal or plastic containers with tight covers, or in bins which are easily sanitized. If using plastic bags for dry bulk food storage, food grade bags must be used. Scoops should not be left in the containers. Do not add more product to a bin container until it is empty and sanitized. Bins/containers are to be labeled, covered and dated. If lining bins use food grade bags. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Characteristics code 4-102.11, the code indicated, The safety and quality of food can be adversely affected through single service and single use articles that are not constructed of acceptable materials. The migration of components of those materials to food they contact could result in chemical contamination and illness to the consumer. In addition, the use of unacceptable materials could adversely affect the quality of the food because of odors, tastes, and colors transferred to the food.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interviews and record reviews the facility failed to ensure one of five sampled residents (Resident 3) was free from chemical restraints (a form of medical restraintˆin which a drugˆis used to restrict the freedom of movement of a patient or in some cases to sedate the patient) by failing to: Ensure Resident 3's physician order dated 4/1/2026 for Haloperidol (Haldol, a type of medication used to treat the symptoms of schizophrenia [a mental illness that affects thoughts, mood, and behavior]) 10 milligrams (mg: unit of measurement) at bedtime specified resident specific behavior manifestations (observable actions, reactions, and physical, visible expressions of an underlying psychological state, emotional condition, or physiological disorder). This failure had the potential for Resident 3 to become over-medicated, restrict mobility, and experience adverse side effects (unexpected or harmful consequences of medication) of Haldol such as dizziness, sedation (a decrease in awareness), blurred vision, and constipation (infrequent bowel movements).Findings: During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 9/19/2023 with diagnoses that included mood affective disorder (a mental health condition involving long-term emotional disturbances), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), and anxiety (a mental health condition characterized by feelings of fear, dread and uneasiness that interfere with daily activities). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 2/25/2026, the MDS indicated the resident had severely impaired cognition (a significant decline in the ability to think, understand, and reason). The MDS indicated Resident 3 required substantial/maximal assistance (helper does more than half the effort) from facility staff with eating and oral hygiene. The MDS indicated Resident 3 was dependent on facility staff for help with toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 3 was taking antipsychotic medication (medication used to treat schizophrenia). During a review of Resident 3's Psychotherapeutic Drug Informed Consent Form dated 3/26/2026, the Psychotherapeutic Drug Informed Consent Form indicated informed consent (voluntary agreement to accept treatment and/or procedure after receiving education regarding the risks, benefits, and alternatives offered) was received from the resident's surrogate decision maker (a person authorized to make healthcare decisions for someone else who has become incapacitated) for Haldol 10 milligrams (mg, and unit of mass) at bedtime for schizophrenia manifested by auditory hallucinations (hearing voices or noises that don't exist in reality). During a review of Resident 3's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/1/2026 for Haldol 10 mg at bedtime for responding to internal stimuli related to schizoaffective disorder. During a review of Resident 3's Medication Administration Record (MAR) dated 3/27/2026 - 3/31/2026, the MAR indicated Resident 3 received five doses of Haldol 10 mg at bedtime for manifestations of responding to internal stimuli related to schizoaffective disorder. The MAR indicated Resident 3 had three instances of responding to internal stimuli on the evening shift on 3/31/2026. During a concurrent interview and record review on 4/02/2026 at 11:03 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 3's physician orders dated 3/27/2026 and 4/1/2026 were reviewed. LVN 1 stated Resident 3 had schizophrenia. LVN 1 stated Resident 3 was taking Haldol for responding to internal stimuli. LVN 1 stated there were physician orders to monitor Resident 3 for behaviors of responding to internal stimuli. LVN 1 stated she (LVN 1) was not sure what responding to internal stimuli meant. LVN 1 stated it would have been easier to monitor Resident 3 for more specific behavior like yelling or talking to herself (Resident 3). During a concurrent interview and record review on 4/2/2026 at 12:58 PM with Registered Nurse 1 (RN 1), Resident 3's physician orders dated 3/27/2026 and 4/1/2026 were reviewed. RN 1 stated Resident 3 was on Haldol for schizophrenia and responding to internal stimuli. RN 1 stated responding (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to internal stimuli referred to how Resident 3 was responding internally to environmental factors. RN 1 stated that the nurses (in general) were supposed to monitor how Resident 3 responded internally to environmental factors, such as noise levels. RN 1 stated the nurses (in general) were supposed to adjust Resident 3's environment based on how the resident responded internally to environmental factors. RN 1 stated the nurses (in general) were not monitoring for specific behavior. RN 1 stated responding to internal stimuli was not a specific behavior. During a concurrent interview and record review on 4/2/2026 at 1:09 PM with RN 2, Resident 3's physician orders dated 3/27/2026 and 4/1/2026 were reviewed. RN 2 stated Resident 3 had physician orders for Haldol 10 mg for schizophrenia manifested by responding to internal stimuli. RN 2 stated responding to internal stimuli referred to Resident 3 having auditory or visual hallucinations. RN 2 stated responding to internal stimuli was a broad manifestation which could cover all of Resident 3's behavioral symptoms. RN 2 stated that if the physician order for Haldol had a manifestation that was more specific, it would be easier to monitor Resident 3 for that specific behavior. RN 2 stated there was a potential that the licensed nurses would interpret the manifestation of responding to internal stimuli differently which could lead to the resident's behaviors not being monitored accurately. During a concurrent interview and record review on 4/3/2026 at 8:31 AM with the Director of Nursing (DON), Resident 3's physician orders dated 3/27/2026 and 4/1/2026 were reviewed. The DON stated Resident 3 had physician orders for Haldol 10 mg for schizophrenia manifested by responding to internal stimuli. The DON stated the manifestation for responding to internal stimuli was not specific enough to be monitored. The DON stated there was a potential for the licensed nurses to have different interpretations of responding to internal stimuli. The DON stated she (the DON), had difficulty explaining what responding to internal stimuli meant. The DON stated the behavior manifestation for Resident 3's Haldol order should have been a more specific behavior such as an auditory hallucination. The DON stated there was a potential for Resident 3 to become overmedicated and experience side effects of Haldol if the resident's behaviors were not interpreted or monitored accurately. During a review of the facility's Policy and Procedure (P&P) titled Antipsychotic Medication Use dated 1/15/2026, the P&P indicated Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, specific symptoms, and risks to the resident and others. The attending physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic medications.

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University Park Healthcare Center	230 E Adams Blvd Los Angeles, CA 90011

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review the facility failed to update and revise the tube feeding (TF, a form of nutrition that is delivered into the digestive system as a liquid) care plan (a plan of care that summarizes a resident's health conditions, current treatments, and specific care and services facility staff (in general) need to provide a resident to promote healing and prevent a worsening of a condition) for one out of one sampled resident (Resident 5) after a new TF order was received on 3/27/2026. This failure had the potential for Resident 5 to receive care that was not in alignment with the resident's needs.Findings: During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 8/20/2025 with diagnoses that included, adult failure to thrive (a syndrome common in older adults that is characterized by unintentional weight loss, decreased appetite, poor nutrition, and physical inactivity), dysphagia (difficulty swallowing), and gastrostomy (g-tube, a surgical opening fitted with a device to allow nutrients to be administered directly to the stomach). During a review of Resident 5's Care Plan Report dated 9/9/2025, the Care Plan Report indicated the resident was on tube feeding related to dysphagia. The Care Plan Report indicated a goal for Resident 5 was to maintain adequate nutritional and hydration status as evidenced by having stable weight and no signs or symptoms of malnutrition (an imbalance between the nutrients your body needs to function and the nutrients it gets) or dehydration (a condition caused by the loss of too much fluid from the body). The Care Plan Report included an intervention that indicated the resident was to receive Jevity 1.5 (a type of high calorie TF formula) at 55 milliliters (a metric unit of volume) per hour (ml/hr) for 20 hours. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool) dated 3/7/2026, the MDS indicated the resident had severe cognitive impairment (a significant decline in the ability to think, understand, and reason). The MDS indicated Resident 5 was dependent on staff for help with oral hygiene, toileting hygiene, showering/bathing, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 5 had a feeding tube. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 3/27/2026 for Glucerna 1.2 via the g-tube at 70 ml/hr for 20 hours for a total of 1400 ml. During a concurrent interview and record review on 4/2/2026 at 1:04 PM with Registered Nurse 1 (RN 1), Resident 5's Care Plan Report dated 9/9/2025 and physician order dated 3/27/2026 were reviewed. RN 1 stated Resident 5 was on tube feeding. RN 1 stated Resident 5 had physician orders to be on Glucerna 1.2 at 70 ml/hr. RN 1 stated Resident 5 had a care plan for tube feeding which indicated the resident was on Jevity 1.5 at 55 ml/hr. RN 1 stated Resident 5's tube feeding care plan had to be revised and updated to include the resident's current physician orders for Glucerna 1.2. RN 1 stated Resident 5's care plan had to reflect the resident's current plan of care. RN 1 stated the purpose of a care plan was to guide the staff (in general) on how to provide care for Resident 5. RN 1 stated Resident 5's care plan listed interventions that staff were to follow when caring for Resident 5. RN 1 stated there was potential for the staff (in general) not to be updated on Resident 5's current plan of care which could affect the care received. During a concurrent interview and record review on 4/3/2026 at 8:20 AM with the Director of Nursing (DON), Resident 5's Care Plan Report dated 9/9/2025 and physician order dated 3/27/2026 were reviewed. The DON stated Resident 5 was on tube feeding and had physician orders for Glucerna 1.2 at 70 ml/hr. The DON stated Resident 5's care plan for tube feeding indicated the resident was on Jevity 1.5 at 55 ml/hr. The DON stated Resident 5's tube feeding care plan was not updated when the resident received new physician orders for Glucerna 1.2 at 70 ml/hr on 3/27/2026. The DON stated Resident 5's care plan should have been revised and updated when new physician orders were received. The DON stated the care plan had to reflect Resident 5's current plan of care. The DON stated the care plan indicated the kind of care the resident was to receive at the facility. The DON stated if the care plan was not updated there (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was potential for Resident 5 to receive care that was not in alignment with the resident's needs. During a review of the facility's Policy and Procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 1/15/2026, the P&P indicated A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review the facility failed to ensure the Dialysis (process of removing waste products and excess fluid from the body) Communication Record was completed for one of two sampled residents (Resident 1) who received dialysis treatment every Monday, Wednesday, and Friday. This failure had the potential to place Resident 1 at risk for a delay in detecting and treating complications related to dialysis such as infection, bleeding, and hypotension (low blood pressure).Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility re-admitted the resident on 11/12/2024 with diagnoses that included End Stage Renal Disease (ESRD, irreversible kidney failure) and dependence on renal dialysis. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 3/1/2026, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 1 required set-up or clean-up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with upper body dressing and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance from staff (helper does less than half the effort) with toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 was receiving dialysis treatment. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 3/2/2026 for dialysis every Monday, Wednesday, and Friday at the dialysis center. During a review of the facility's undated Dialysis Communication Record form, the Dialysis Communication Record form indicated it was to be completed by a licensed nurse at the facility before (pre) dialysis, completed by the dialysis center during dialysis, and completed by a licensed nurse at the facility after (post) dialysis. During a review of Resident 1's Dialysis Communication Records dated 3/9/2026 - 4/1/2026, the Dialysis Communication Records indicated the post dialysis assessment was not completed for Resident 1 on 3/11/2026, 3/16/2026, and 3/20/2026. The Dialysis Communication Records dated 3/11/2026, 3/16/2026, and 3/20/2026 indicated there was no documentation under the post dialysis assessment section regarding Resident 1's cognitive status, vital signs, dialysis access site, or breathing patterns. There were no Dialysis Communication Records for Resident 1 dated 3/23/2026, 3/25/2026, 3/27/2026, and 3/30/2026. During a concurrent interview and record review on 4/02/2026 at 9:52 AM with Registered Nurse 2 (RN 2), Resident 1's Dialysis Communication Records dated 3/9/2026 - 4/1/2026 were reviewed. RN 2 stated the Dialysis Communication Record was a form that accompanied the resident to and from dialysis. RN 2 stated the licensed nurses were responsible for filling out and completing the Dialysis Communication Record pre and post dialysis. RN 2 stated a Dialysis Communication Record had to be completed every time Resident 1 went to dialysis. RN 2 confirmed by stating the Dialysis Communication Record for Resident 1 was not completed by a licensed nurse post dialysis on 3/11/2026, 3/16/2026, and 3/20/2026. RN 2 stated there was no Dialysis Communication Record for Resident 1 on 3/23/2026, 3/25/2026, 3/27/2026, and 3/30/2026. RN 2 stated the Dialysis Communication Record for Resident 1 should have been completed by a licensed nurse post dialysis on 3/11/2026, 3/16/2026, and 3/20/2026. RN 2 stated the Dialysis Communication Record should have been completed by the facility and the dialysis center on 3/23/2026, 3/25/2026, 3/27/2026, and 3/30/2026. RN 2 stated the purpose of the Dialysis Communication Record was to monitor Resident 1 throughout the dialysis process. RN 2 stated the Dialysis Communication Record ensured that from the facility to the dialysis center and back to the facility, Resident 1 remained stable. RN 2 stated the Dialysis Communication Record would help to identify if Resident 1 had a change of condition during the dialysis process. RN 2 stated if the Dialysis Communication Record was not completed there was potential for Resident 1 to have a change of condition that was not identified and treated promptly. During a concurrent interview and record (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review on 4/03/2026 at 8:15 AM with the Director of Nursing (DON), Resident 1's Dialysis Communication Records dated 3/9/2026 - 4/1/2026 were reviewed. The DON confirmed by stating the post dialysis assessments on the Dialysis Communication Records were not completed for Resident 1 on 3/11/2026, 3/16/2026, and 3/20/2026. The DON stated the Dialysis Communication Record was not completed on 3/23/2026, 3/25/2026, 3/27/2026, and 3/30/2026. The DON stated the Dialysis Communication Record had to be completed before, during, and after Resident 1 had dialysis. The DON stated the Dialysis Communication Record had to be completed with every dialysis session. The DON stated the Dialysis Communication Record was an assessment used to ensure residents were stable. The DON stated the Dialysis Communication Record ensured the licensed nurses monitored the residents' vitals and dialysis site for any changes. The DON stated if the Dialysis Communication Record was not completed pre, during, and post dialysis, Resident 1 could potentially have had a change of condition that was not monitored and treated. During a review of the facility's Policy and Procedure (P&P) titled Hemodialysis Access Care dated 1/15/2026, the P&P indicated The general medical nurse should document in the resident's medical record every shift as follows: Location of catheter, condition of dressing (interventions if needed), if dialysis was done during shift, any part of report from dialysis nurse post-dialysis being given, observations post-dialysis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to: Store unopened insulin lispro (a medication used to control blood sugar) in the refrigerator per the manufacturer's requirements in one of two inspected medication carts (Medication Cart 2.)Store gabapentin solution (a medication used to treat pain) in the refrigerator per the manufacturer's requirements in one of two inspected medication carts (Medication Cart 1). The deficient practice of failing to store medications in the refrigerator according to the manufacturer's requirements, increased the risk that residents could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death.Findings: During a concurrent observation and interview on 4/1/2026 at 11:01 AM of Medication Cart 2 with the Licensed Vocational Nurse (LVN 4), one unopened insulin lispro pen was found stored at room temperature without a labeled open date. The insulin lispro pen product labeling indicated unopened insulin lispro pens had to be stored in the refrigerator. LVN 4 stated the lispro stored in the cart was unopened and should have been stored in the refrigerator. LVN 4 stated if insulin was stored at the wrong temperature, it could affect the potency of the medication which could lead to a loss of blood sugar control and other medical complications. During a concurrent observation and interview on 4/1/2026 at 11:11 AM of Medication Cart 1 with LVN 2, one prescription bottle of gabapentin solution 250 milligrams (mg - a unit of measure for mass) per 5 milliliters (ml - a unit of measure for volume) was found stored at room temperature. The gabapentin solution product and pharmacy labeling indicated the gabapentin solution had to be stored in the refrigerator. LVN 2 stated the gabapentin solution was stored in the cart at room temperature. LVN 2 stated, per the pharmacy label, gabapentin solution had to be stored in the refrigerator. LVN 2 stated she did not know how long the gabapentin solution had been stored at room temperature. LVN 2 stated failing to store gabapentin solution in the refrigerator could cause the medication not to work as well leading to seizures, increased pain, or other medical complications. A review of the facility's policy Storage of Medications, revised November 2020, indicated The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured locations.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on observation and interview the facility failed to ensure one of one sampled resident (Resident 1) was made aware of pre-appointment instructions for a Computed Tomography (CT, an imaging procedure used to create detailed images of internal body structures) angiogram (a procedure that uses dye to visualize blood throw through arteries or veins) and cardiac echocardiogram (cardiac echo, an ultrasound test that creates images of the heart's structure) as scheduled on 3/30/2026 at 10 AM as per physician's orders dated 2/18/2026. As a result, Resident 1 could not have the CT angiogram done on 3/30/26, placing the resident at risk for a delay in care and treatment.Findings: During a review of Resident 1's admission Record, the admission Record indicated the facility re-admitted the resident on 11/12/2024 with diagnoses that included End Stage Renal Disease (ESRD, irreversible kidney failure), dependence on renal dialysis (process of removing waste products and excess fluid from the body), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (mild or partial weakness or loss of strength on one side of the body), hypertension (high blood pressure), and hepatic failure (loss of liver function). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 3/1/2026, the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 1 required set-up or clean-up assistance (helper sets up or cleans up) with eating and oral hygiene. The MDS indicated Resident 1 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with upper body dressing and personal hygiene. The MDS indicated Resident 1 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, showering/bathing, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 1 received dialysis treatment. During a review of Resident 1's Order Summary Sheet, the Order Summary Sheet indicated the resident had a physician order dated 2/18/2026 for an appointment to have a CT angiogram and cardiac echo on 3/30/2026 at 10 AM. The physician order indicated that dialysis for Resident 1 had to be scheduled within four to five hours after the appointment. The physician order indicated Resident 1 had to fast (have no food or drink) for four hours before the appointment. The physician order indicated Resident 1 could not have caffeine 24 hours before the appointment. During an interview on 3/31/2026 at 10:20 AM with Resident 1, Resident 1 stated he (Resident 1) was supposed to have a CT angiogram on 3/30/2026 and fast before the CT angiogram. Resident 1 stated he (Resident 1) was supposed to go to the appointment for the CT angiogram before dialysis and stated the nurses (in general) did not communicate any information or instructions about the CT angiogram appointment to him (Resident 1). Resident 1 stated he (Resident 1) went to the appointment for the CT angiogram after having dialysis on 3/30/2026. Resident 1 stated he (Resident 1) ate food before going to the appointment for the CT angiogram. Resident 1 stated he (Resident 1) could not have the CT angiogram done because he (Resident 1) ate food and had dialysis before the appointment. Resident 1 stated the appointment for the CT angiogram had to be rescheduled to 4/15/2026. Resident 1 stated he (Resident 1) was frustrated because the CT angiogram could not be done on 3/30/2026. During an interview on 4/2/2026 at 12 PM with the Social Services Director (SSD), the SSD stated Resident 1 had an appointment on 3/30/2026 for a CT angiogram and cardiac echo. The SSD stated Resident 1 was supposed to fast for four hours before the appointment and go to dialysis after the appointment. The SSD stated that on the day of the appointment Resident 1 went to dialysis before the appointment. The SSD stated that on 3/30/2026 at 9:30 AM, she (the SSD) received a call that Resident 1 could not have the CT angiogram and cardiac eco because the resident had already eaten and had dialysis. The SSD stated that on 3/27/2026 she (the SSD) posted a communication on the facility's care communication board as a reminder that Resident 1 had an appointment on 3/30/2026. The SSD (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated instructions on fasting and attending dialysis after Resident 1's appointment was also included as part of the resident's physician order dated 2/18/2026. The SSD stated that she (the SSD) and Registered Nurse 2 (RN 2) were responsible for communicating the appointment instructions and information to Resident 1. The SSD confirmed by stating the instructions to fast and have dialysis after the appointment were not communicated to Resident 1. The SSD stated Resident 1's dialysis was supposed to be rescheduled for a later time on 3/30/2026 but stated that it was not done. The SSD stated Resident 1's appointment for a CT angiogram and cardiac echo had to be rescheduled for 4/15/2026. During an interview on 4/2/2026 at 1:15 PM with RN 2, RN 2 stated Resident 1 had physician orders for a CT angiogram and cardiac echo appointment on 3/30/2026. RN 2 stated Resident 1 was supposed to be fasting prior to the CT angiogram appointment. RN 2 stated Resident 1 was supposed to have the CT angiogram and cardiac echo done prior to going to dialysis. RN 2 stated that on 3/30/2026 Resident 1 went to dialysis before the resident's appointment for the CT angiogram. RN 2 stated she (RN 2) was informed that Resident 1 could not have the CT angiogram and cardiac echo done because the resident had eaten, so the resident returned to the facility. RN 2 stated she (RN 2) and the SSD were responsible for communicating with Resident 1 the need for fasting and going to the appointment before dialysis. RN 2 confirmed by stating the appointment and dialysis instructions were not communicated to Resident 1. RN 2 stated relaying the instructions for Resident 1's appointment got missed. RN 2 stated Resident 1's dialysis was supposed to be rescheduled for a later time on 3/30/2026 but stated that it was not done. RN 2 stated Resident 1's appointment for a CT angiogram and cardiac echo had to be rescheduled for 4/15/2026. During an interview on 4/3/2026 at 8:24 AM with the Director of Nursing (DON), the DON stated Resident 1 had a physician order for a CT angiogram and cardiac echo appointment on 3/30/2026. The DON stated Resident 1's physician order indicated the resident had to fast for four hours before the appointment and was to have dialysis after the appointment. The DON stated the SSD, and the RN supervisors were responsible for communicating the appointment instructions with Resident 1. The DON stated Resident 1 did not have the CT angiogram and cardiac echo on 3/20/2026 as scheduled because the appointment instructions were not communicated with the resident. In addition, the DON stated Resident 1's dialysis on 3/30/2025 was not scheduled for later in the day. The DON stated it was important for facility staff to communicate with residents regarding appointments and care plans. The DON stated that without communication important details could be missed. The DON stated there was a potential for Resident 1 to have a delay in care and treatment because the resident missed the CT angiogram and cardiac echo appointment. During a review of the facility's Policy and Procedure (P&P) titled Referrals, Social Services dated 1/15/2026, the P&P indicated Social services personnel shall coordinate most resident referrals with outside agencies. Social services shall coordinate most resident referrals. Exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff.Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.Social services will help arrange transportation to outside agencies, clinical appointments, etc., as appropriate. During a review of the facility's P&P titled Use of Outside Resources dated 1/15/2026, the P&P indicated The facility recognizes the importance of utilizing outside resources to provide comprehensive care and support to residents. The facility will determine if outside resources are necessary to meet the needs of residents. Resident's medical condition, functional status, psychosocial needs, and preferences will be taken into consideration by the Interdisciplinary team when identifying the need for outside resources.The facility will comply with all applicable laws, regulations, and guidelines related to the use of outside resources.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that call light (a device with a button or touch pad a resident uses to set off an alarm that flashes/rings to alert the facility staff the resident needs assistance) was within reach for one of six sampled residents (Resident 68). This deficient practice had the potential to result in staff delay in meeting Resident 68's needs for activities of daily living (ADLS, activities a person performs daily such as bathing, dressing, and toileting), prolonged distress and increased risk of falls for Resident 68.Findings: During a review of Resident 68's admission Record, the record indicated the facility originally admitted Resident 68 on 2/7/2025 and readmitted the resident on 3/13/2026, with diagnoses that included spondyloarthropathy (a chronic autoimmune disease that causes pain and stiffness of the joints) of the spine, dementia (a progressive state of decline in mental abilities) and major depression disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 68's Fall Risk assessment dated [DATE], the assessment indicated the resident was at moderate risk for falls. During a review of Resident 68's Minimum Data Set (MDS, a resident assessment tool), dated 2/4/2026, the MDS indicated the resident required maximum assistance (helper does more than half the effort) from staff in completing ADLS. During a review of Resident 68's care plan revised on 3/22/2026, the care plan indicated Call light with easy reach and answer promptly. During an interview on 3/31/2026 at 10:49 a.m., Resident 68 stated she was unable to get up or reposition herself to a sitting position without assistance. Resident 68 stated she relied on using the call light to call for help and asked where the call light was because she (Resident 68) could not find the call light after staff had changed her bed linens earlier that day (3/31/26). During a concurrent observation and interview on 3/31/2026 at 11:01 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 68's room, the cord for Resident 68's call light was observed to be clipped to the bedsheet at the head of the bed. The call light was dangling off the left side of the bed. CNA 1 stated the call light was not within Resident 68's reach. CNA 1 stated the call light should have been within reach so the resident could press the call light to call for help. During an interview on 4/2/2026 at 9:38 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated it was not acceptable for call lights to be out of residents reach. LVN 4 stated residents with limited mobility would try to reach for the call light or move without assistance, which could lead to falls. During an interview on 4/3/2026 at 8:27 a.m. with the Registered Nurse Supervisor (RN), RN 2 stated call lights should be clipped on the bed within residents reach. RN 2 stated it can be stressful for residents when they cannot reach the call light to call for help. During a concurrent interview and record review the facility's policy and procedure (P&P) titled, Answering the Call Light, dated January 2026 on 4/3/26 at 8:31 a.m. with the Director of Nursing (DON), the DON reviewed the policy and stated it was not acceptable for call lights to be out of reach when residents needed to use the call lights. The DON stated the P&P was not followed. During a review of the facility's P&P titled, Answering the Call Light, dated January 2026, the P&P indicated, When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.