

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Sherman Oaks Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 14401 Huston St. Sherman Oaks, CA 91423	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach for three of five sampled residents (Residents 5, 57, 31) reviewed under environment task. This deficient practice had the potential to result in a delay in care, and inability to ask for assistance when needed. Findings: 1. During a review of Resident 5's Face Sheet (FS), the FS indicated the facility admitted the resident on 9/22/2025, and readmitted the resident on 6/24/2026, with diagnoses including depression (a serious mental health condition characterized by persistent sadness, low energy, and a loss of interest in activities), aphasia (a disorder that makes it difficult to speak), and lack of coordination. During a review of Resident 5's History and Physical (H&P), dated 6/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/3/2026, the MDS indicated the resident sometimes had the ability to make self-understood, sometimes had the ability to understand others and had moderately impaired vision. The MDS indicated the resident had moderately impaired cognitive skills (a person has noticeable trouble with thinking, learning, remembering, and making decisions) and was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 5's Fall Risk Evaluation (FRE), dated 6/25/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 5's Care Plan (CP) Report regarding the resident being at risk for falls/injury related to aging process, limited mobility, cognitive and communication impairment., last revised on 6/28/2026, the CP indicated an intervention to keep the call light within easy reach and encouraged resident to use it to get assistance. During a concurrent observation and interview on 6/29/2026, at 10:39 a.m., with Certified Nursing Assistant (CNA) 1, inside Resident 5's room, observed Resident 5's call light was touching the floor at the left side of the bed. CNA 1 stated the call light of Resident 5 was not accessible to the resident as it was almost touching the floor. CNA 1 stated everybody is responsible for making sure the call light of the residents were within reach so they can call for help when needed. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 056250	Facility ID: 056250 If continuation sheet Page 1 of 61

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/1/2026, at 12 p.m., with the Minimum Data Set-Registered Nurse (MDS-RN), Resident 5's Medical Diagnoses, FRE, CPs, and Policies and Procedures (P&P) were reviewed. The MDS-RN stated the call light of Resident 5 should be within reach of the resident so they can call for help when needed. The MDS-RN stated the resident was at risk for falls and could fall while reaching for the call light on the floor. The MDS-RN stated the CP regarding the resident being at risk for falls/injury related to aging process, limited mobility, cognitive and communication impairment., last revised on 6/28/2026, and the P&P titled, Call System, Residents, last reviewed on 9/27/2025, were not followed because they failed to ensure the call light was within reach and the resident was not able to call for help at that time. During an interview and record review on 7/2/2026, at 11:01 a.m., with the Director of Nursing (DON), Resident 5's CP regarding the resident being at risk for falls/injury related to aging process, limited mobility, cognitive and communication impairment., and the P&P titled, Call System, Residents were reviewed. The DON stated Resident 5's call light should be always within reach so the resident can call when they need help. The DON stated all staff was responsible for ensuring the call light was within reach of the residents. The DON stated they should be checking the resident's environment for hazards to prevent accidents from happening. The DON stated that when they do their safety rounds and while providing care to the residents they should always be checking for the accessibility of the call light to residents. The DON stated the failure of the staff to ensure the call light of Resident 5 was within reach could lead to accidents such as falls. The DON also stated Resident 5's CP and the facility's P&P titled, Call System, Residents were not followed because they failed to keep the call light of Resident 5 within reach. 2. During a review of Resident 57's FS, the FS indicated the facility admitted the resident on 1/6/2026, with diagnoses including weakness, visual loss, and history of falling. During a review of Resident 57's H&P, dated 1/12/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 57's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood, understand others, and had severely impaired vision. The MDS indicated the resident had severe cognitive impairment (a serious, often irreversible loss of brain function that severely affects memory, reasoning, and orientation to time, place, or people) and the resident was dependent to needing partial assistance on mobility and ADLs. During a review of Resident 57's FRE, dated 4/21/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 57's CP Report titled, Resident is at risk for falls/injury related to aging process, limited mobility, unsteady balance, vision impairment., last revised on 5/1/2026, the CP indicated an intervention to keep call light within easy reach and encourage resident to use it to get assistance. During a concurrent observation and interview on 6/29/2026, at 10:29 a.m., with CNA 3, inside Resident 57's room, observed Resident 57's call light was on the floor, at the right side of the bed. (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised on 6/08/2026, the CP indicated a goal to reduce risk of falls and injury daily until the next assessment. The CP intervention was to keep the call light within easy reach and encourage the resident to use it to get assistance. During a concurrent observation and interview on 6/29/2026, at 10:10 a.m., with Certified Nursing Assistant (CNA) 2 inside Resident 31's room, CNA 2 observed call light and bed remote control were hanging on the right side of the resident's bed. CNA 2 stated that the call light should be within reach of the resident because Resident 31 can potentially fall trying to reach for the call light. During a concurrent interview and record review on 7/1/2026, at 12:23 p.m., with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 31's FRE, and CPs were reviewed. The MDS-RN stated Resident 31 is at high risk for falls. The MDS-RN stated the position of the call light can predispose resident to fall. The MDS-RN stated that the CP, policy and procedure Call System, Residents, was not followed. During an interview on 7/2/2026, at 11:15 a.m., with the DON, the DON stated the call light should be within reach of the resident and staff are responsible for making sure the call light is within resident's reach. The DON stated the purpose of the call light is for the resident to call for assistance and if the call light is not within reach the resident can fall trying to reach for the call light. The policy and procedure Call System, Residents, was not followed. During a review of the facility's recent P&P titled, Call System, Residents, last reviewed on 9/27/2025, the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident was treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one of three sampled residents (Resident 26) reviewed for physical restraints by failing to ensure that Resident 26's use of restraint bed placed against the wall had a current physician's order, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), restraint assessment, and a care plan (a document outlining a detailed approach to care customized to an individual resident's need). This deficient practice had the potential to result in the restriction of resident's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from the resident limbs getting entrapped from bed spaces leading to fractures (a broken bone). Findings: During a review of Resident 26's Face Sheet (FS) dated 7/02/2026, the FS indicated that the facility originally admitted the resident on 7/26/2019 and readmitted on [DATE], with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one entire side of the body) following cerebral infarction (loss of blood flow to a part of the brain) affecting left non-dominant side, major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), tobacco use, cramp and spasm. During a review of Resident 26's History and Physical (H&P), dated 4/03/2026, the H&P indicated that the resident had the capacity to understand and make medical decisions. During a review of Resident 26's Minimum Data Set (MDS - a resident assessment tool) dated 5/06/2026, the MDS indicated that the resident had the ability to make self-understood and understand others. The MDS indicated the resident needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity), and substantial/maximal assistance (helper does more than half the effort) when performing oral and personal hygiene, toileting and bathe self; and partial to moderate assistance with transfers. During a review of Resident 26's Care Plan (CP) titled, ADL/Self-care Deficit, Resident require assistance with activities of daily living because of aging process, limited mobility, unsteady balance, poor coordination, forgetfulness, initiated on 3/11/2024, the CP indicated an intervention including to assist resident with turning and repositioning when needed and provide a safe environment. During an initial observation and interview on 6/29/2026 at 10:22 a.m. with Resident 26 inside the resident's room, Resident 26 stated that his bed was adjacent to the wall and was unable to remember the time of its placement. Resident 26 stated that he (Resident 26) has limited range of motion to his left upper and lower extremities due to stroke. During a concurrent observation and interview on 6/30/2026 at 7:57 a.m. with Infection Prevention (IP) nurse, inside Resident 26's room, the IP nurse stated that Resident 26's left side of the bed was placed against the wall. During a concurrent interview and record review on 7/01/2026 at 10:49 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that if bed is placed against the wall, it is considered a restraint. The ADON reviewed Resident 26's medical record and stated that there was no assessment, consent, doctor's order, and care plan made for bed placed against the wall. The ADON stated that assessment is important for the safety of the resident and consent that the resident agreed for the bed placed adjacent to the wall. The ADON further stated that there should have been a doctor's order and care (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan for other staff to know how to care for resident with bed placed against the wall. The ADON stated that the resident could possibly hurt himself when his limbs get caught which could potentially lead to injury. During a concurrent observation and interview on 7/02/2026 at 12:05 p.m. with the Director of Nursing (DON), the DON stated that when bed is placed against the wall, it is considered a restraint. The DON stated that there must be an assessment, consent, MD order and care plan before putting the bed against the wall. The DON stated that it can cause entrapment and potentially lead to injury to the resident. The DON stated the policy for restraints was not followed. During a review of the facility's Policy and Procedures (P&P) titled, Use of Restraints, revised on 9/27/2025, the P&P indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. When the use of restraints is indicated, the least restrictive will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented. 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptom to determine if there are less restrictive interventions (programs, devices, referrals, etc.) that may improve the symptoms. 3. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 4. Care plans for residents will reflect interventions that address not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s). 5. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment free from accidents and hazards by failing to: 1. Ensure residents were not left unattended by staff with the bed in the high / elevated position (a working height (typically that allows caregivers and nurses to perform medical tasks comfortably) for one of six sampled residents (Resident 10) reviewed for Accidents. 2. Ensure the bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was connected and functioning for one of two sampled residents (Resident 49) reviewed for Physical Restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body). These deficient practices had the potential to result in resident falls resulting in injuries like fractures (broken bones) and lacerations. 3. Ensure residents who require supervision while smoking did not have cigarettes and a lighter when left unattended by staff for one of six sampled residents (Resident 117) reviewed for Accidents. This deficient practice had the potential to result in resident injuries from burns and fires. 4. Ensure bed remote control (a handheld device used to operate an adjustable bed) to one of seven sampled residents (Resident 5) did have frayed wires on them. 5. Ensure floor mats (a cushioned floor pad designed to help prevent injury should a person fall) for two of seven sampled residents (Resident 48 and Resident 31) did not have equipment or furniture on top of them. These deficient practices increase the risk of accidents such as falls with injuries and electrocution on residents. 6. Ensure one of three sampled residents (Resident 103) reviewed for accidents did not have any medications or biologicals left at the resident's bedside table.^ This deficient practice increased the potential to result in resident harm from overdose of medication, and when ingesting medication that could potentially have a drug interaction which could result to adverse reactions. Findings: a. During a review of Resident 10's admission Record (AR or Face Sheet), the AR indicated that the facility admitted the resident on 10/1/2020 and most recently re-admitted the resident on 2/20/2026, with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic pain syndrome (a condition where pain lasts longer than three months), osteoarthritis (OA, a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left shoulder and right knee, and dementia (a general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life).^ During a review of Resident 10's History and Physical (H&P), dated 2/20/2026, the H&P indicated the resident had the capacity to make medical decisions, and the plan of care included fall precautions. During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 6/5/2026, the MDS indicated the resident had the ability to make herself understood and had the ability to understand others. The MDS indicated the resident required substantial / maximal assistance from staff with bathing, and lower body dressing; required partial / moderate assistance with toileting, personal hygiene, and upper body dressing. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10's Fall Risk Evaluation dated 6/19/2026, the Fall Risk Evaluation indicated the resident had intermittent confusion, had balance problems when walking, had jerking or was unstable when making turns, required the use of assistive devices, and the resident had a fall risk score of 21 (an evaluation to predict risk for falls - when the total score is 10 or greater, the resident should be considered at high risk for falls). During a review of Resident 10's Care Plan (CP) titled, Falling Star Program. At risk for falls related to: aging process, limited mobility, unsteady balance, pain, use of narcotics (pain medication), ., activities of daily living function varies, tremors, . and other medical conditions such as Parkinson's Disease,. OA, ., chronic pain syndrome, muscle spasms, . dementia, ., initiated 3/11/2025 and last reviewed 6/19/2026, the CP indicated a goal to reduce risk of fall and/or injury thru appropriate interventions daily that included to post signs that identify the resident as a high risk for falls and frequent visual monitoring. During a review of Resident 10's CP titled, Resident is at risk for falls/injury., initiated 3/11/2025 and last reviewed 6/19/2026, the CP indicated to provide the resident with a safe environment. During an observation on 6/29/2026 at 11:02 a.m., observed Resident 10 lying in bed with the bed in the high, elevated position and no staff were in the room. During an observation on 6/29/2026 at 11:29 a.m., observed Licensed Vocational Nurse (LVN) 1 standing at the doorway of Resident 10's room, looking in toward Resident 10. Observed Resident 10's bed remained in the elevated/high position. Observed LVN 1 then walked down the hallway and left the resident unattended. During a concurrent observation and interview on 6/29/2026 at 11:40 a.m., with Certified Nursing Assistant (CNA) 4, CNA 4 stated she (CNA 4) was not Resident 10's assigned CNA today, but she (CNA 4) has cared for the resident in the past. CNA 4 stood at the room entrance and stated Resident 10's bed was in the high position because she (Resident 10) wanted it that way. Observed CNA 4 then walked away from the room and down the hallway while Resident 10's bed remained in the high position. During a follow up concurrent observation and interview on 6/29/2026 at 11:40 a.m., in Nursing Station 2, with LVN 1, LVN 1 stated Resident 10's bed was left in the high position, and the resident was able to say if she (Resident 10) wanted the bed lowered. Observed LVN 1 walked to Resident 10's room and stated that the bed was in the high position. Resident 10 stated it was ok to lower the bed. Upon exiting the room, LVN 1 stated the CNA must have left Resident 10's bed in the high position. LVN 1 stated Resident 10 should have had the bed in the low position, but it was not. LVN 1 stated she (LVN 1) should have asked Resident 10 if the bed could be lowered when she (LVN 1) was in the room earlier, but she (LVN 1) did not. LVN 1 stated it was important to lower the bed after providing resident care for resident safety because a resident is more at risk for injury from a fall when the bed is left high. During an interview on 6/29/2026 at 11:59 a.m., with Resident 10, Resident 10 stated she (Resident 10) did not know how to raise and lower the bed, she (Resident 10) was not aware the bed was left in (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the high position, and she (Resident 10) did not remember who raised the bed. Resident 10 stated she (Resident 10) wanted the bed in the low position because she (Resident 10) did not want to fall if she (Resident 10) needed to get up to use the restroom. During a concurrent interview and record review on 7/2/2026 at 10:08 a.m., in the conference room, with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding fall prevention and accidents were reviewed. The DON stated it is the facility practice to lower the resident's bed after providing care because when the bed is left in the high position it may result in falls with injury. The DON stated Resident 10 is at risk for falls and in the Falling Star Program and the bed should not be left in the high position. The DON stated the facility P&P was not followed. During a review of the facility P&P titled, Fall and Fall Risk, Managing, last reviewed 9/27/2025, the P&P indicated, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Environmental factors that contribute to the risk of falls include: . incorrect bed height. Resident conditions that may contribute to the risk of falls include: . cognitive impairment; . pain; .medication side effects; . and functional impairments. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 9/27/2025, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. b. During a review of Resident 49's AR, the AR indicated the facility admitted the resident on 4/17/2025 and re-admitted the resident on 6/10/2025, with diagnoses including cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), dementia, glaucoma (an eye condition causing gradual loss of sight), hearing loss, and history of falling. During a review of Resident 49's MDS, dated [DATE], the MDS indicated the resident usually was able to understand others and usually was able to make himself understood. The MDS indicated the resident was dependent on assistance from staff for toileting, bathing, and transfer mobility. The MDS further indicated the resident used a bed alarm daily while in the facility. During a review of Resident 49's H&P, dated 6/17/2025, the H&P indicated the resident did not have the capacity to understand and make decisions, and the plan of care included fall precautions. During a review of Resident 49's Physician Order Summary, the Physician Order Summary indicated an order for a bed pad alarm on to alert resident to call for assistance due to episodes of getting up unassisted related to dementia, dated 6/11/2025. During a review of Resident 49's CP titled, Resident is at risk for falls/injury related to aging process, limited mobility, unsteady balance, poor safety awareness/judgment,, vision and hearing impairment,. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spontaneous movement/behavior,, tends to get up unassisted,, initiated 6/11/2025 and last reviewed 3/30/2026, the CP indicated to reduce risk of falls and injury daily with the implementation of interventions that included to provide the resident with a safe environment. During a review of Resident 49's CP titled, Bed pad alarm on., initiated 6/11/2025 and last reviewed 5/15/2026, the CP indicated to apply bed pad alarm as ordered and to monitor the alarm for good working condition and proper placement. During an observation on 6/29/2026 at 11:05 a.m., inside Resident 49's room, the resident was in bed awake. Observe a pad alarm box connected to the right-side rail of the bed. Observe Resident 49 turn to the side shifting his body weight off the center of the bed. Observed the pad alarm did not sound. During a concurrent observation and interview on 7/1/2026 at 10:30 a.m. observed Resident 49 lay in bed with no staff in the room, observed the pad alarm box connected to the left side rail and the cord between the pad and alarm box was not connected. Resident 49 stated he (Resident 49) was cold and requested the surveyor to get assistance for the resident. During a concurrent observation and interview on 7/1/2026 at 10:35 a.m. inside Resident 49's room, observed CNA 5 entered Resident 49's room at the request of the surveyor and placed a blanket on the resident. CNA 5 stated Resident 49's call light was next to the resident, and the bed control was next to the pad alarm. Observed CNA 5 touched the bed control directly next to the disconnected pad alarm. CNA 5 then exited the room and the pad alarm remained disconnected. During a concurrent observation and interview on 7/1/2026 at 11 a.m., observed LVN 1 entered Resident 49's room at the request of the surveyor and stated the pad alarm cord was tied to the box and not connected to the pad. Observed Resident 49 shifted all his weight to the right side while LVN 1 searched the bed for the pad. LVN 1 stated the alarm was not sounding when the resident moved, the cord from the alarm box was disconnected, and she (LVN 1) could not find the pad in the resident's bed. LVN 1 stated she (LVN 1) had not checked Resident 49's pad alarm on 7/1/2026. LVN 1 stated CNA 5 should have identified the alarm was disconnected and notified her, but CNA 5 did not. During a follow-up concurrent interview and record review on 7/1/2026 at 11:12 p.m. with LVN 1, Resident 49's physician orders were reviewed. LVN 1 stated Resident 49 had an order for a pad alarm, and the alarm should have been functioning, but it was not. LVN 1 stated she (LVN 1) did not remember checking Resident 49's alarm since 6/29/2026. LVN 1 stated if it was reported that the alarm was not functioning, she (LVN 1) would have checked the alarm. LVN 1 stated Resident 49 was a fall risk, and it was important to ensure the alarm was functioning for the resident's safety so staff could run to his room when the alarm sounded to prevent the resident from falling. During a follow-up interview on 7/1/2026 at 2:47 p.m. with CNA 5, CNA 5 stated it was his mistake and he (CNA 5) should have identified that Resident 49's pad alarm was disconnected and reconnected the pad, but he did not. During a concurrent interview and record review on 7/2/2026 at 10:08 a.m., in the conference room, with the DON, reviewed the facility P&P regarding personal alarms and accidents. The DON stated pad (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	alarms are for residents that have behaviors that put them at risk for falls. The DON stated the alarm should be checked every shift, and any staff should identify alarm issues during resident rounds. The DON stated the P&Ps were not followed when Resident 49's pad alarm was not functioning potentially resulting in a fall with injury. During a review of the facility P&P titled, Personal Alarms, last reviewed 9/27/2025, the policy indicated, This facility will use, as indicated, a sensor pad that conveniently sounds an audible alarm when the sensor detects a patient rising out of the bed/wheelchair reminding the resident to return to a safe position while alerting staff to potential fall . Apply sensor pad on the residents' bed or chair. 7. Nursing will monitor proper functioning and positioning of personal alarm. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 9/27/2025, the policy indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. c. During a review of Resident 117's AR, the AR indicated the facility admitted the resident on 4/19/2024 and re-admitted the resident on 10/28/2024 with diagnoses including dementia, tobacco use, noncompliance with medical treatment, and traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). During a review of Resident 117's MDS dated [DATE], the MDS indicated the resident was usually able to understand others and was usually able to make himself understood. The MDS indicated the resident required substantial/maximal assistance from staff for toileting, dressing, personal hygiene, bathing, and transfer mobility. The MDS further indicated the resident was a current tobacco user. During a review of Resident 117's H&P, dated 10/8/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 117's CP titled, Resident is a smoker and an assessment of resident's capabilities and deficits determines . requires supervision while smoking related to dementia, initiated 11/11/2024 and last revised 5/15/2026, the CP indicated the resident may only smoke in designated areas, had no access to matches and lighters, and needed supervision while smoking. During a review of Resident 117's Social Services Progress Note (SSPN) dated 4/24/2025, the SSPN indicated on 4/23/2025 Resident 117 was smoking in the bathroom and the CNA and medication nurse had the resident hand over his cigarettes and lighters that were then stored in the medication room for safety. Resident 117 was informed that he (Resident 119) would have to ask the nurses for cigarettes during designated smoking hours. During a concurrent observation and interview on 6/29/2026 at 11:13 a.m., inside Resident 117's shared room, observed the resident sitting in a wheelchair at the foot of the bed next to a rolling (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside table visible from the main hallway. Observed on the rolling bedside table a pack of cigarettes and a blue lighter. Resident 117 stated he (Resident 119) was a smoker, and the surveyor could easily see that by looking at his cigarettes and lighter. During an observation on 6/29/2026 at 1:10 p.m., inside Resident 117's shared room, observed Resident 117 sitting on his bed. Observe the cigarette and lighter remained on the bedside rolling table. Observed CNA 6 enter the room, stand at Resident 117's bedside to speak with the resident while the cigarettes and lighter were in view, then exit the room. The cigarette and lighter remained on the table. During a concurrent observation and interview on 6/29/2026 at 4:21 p.m., observed Resident 117 was in the restroom and a pack of cigarettes lay open on the resident's bed. Observed no staff in the room. While standing in the hallway outside Resident 117's room, CNA 7 stated she (CNA 7) was caring for Resident 117 and had just started her shift at 3 p.m. CNA 7 stated Resident 117 was a smoker but should not have cigarettes or a lighter in his room and can only smoke with supervision. Observed CNA 7 entered the resident's room and stated there was a pack of cigarettes on Resident 117's bed and they should not be there. CNA 7 stated all staff are responsible for removing cigarettes and lighters from the resident's room. During an interview on 6/29/2026 at 4:40 p.m., at Nursing Station 2, with LVN 4, LVN 4 stated Resident 117 was a smoker, had episodes of forgetfulness, and could only smoke while supervised. LVN 4 stated a while ago, Resident 117's family member brought him (LVN 4) a blue lighter from the resident's room. LVN 4 stated the lighter was put in the locked medication room. LVN 4 stated a staff member must have given Resident 117 the blue lighter from the medication room, but they should not have. LVN 4 stated any staff, including CNAs, should look around the resident's room every time they enter and remove cigarettes and lighters. LVN 4 stated when Resident 117 had the cigarettes and lighter it was a safety risk with a potential for facility fires when the resident smoked unsupervised. During a concurrent interview and record review on 7/2/2026 at 10:08 a.m., in the conference room, with the DON, reviewed the facility P&P regarding smoking and accidents. The DON stated Resident 117 had a history of smoking noncompliance in the facility and staff should have identified that the resident had his own cigarettes and lighter, but they did not. The DON stated the P&P was not followed when Resident 117 had cigarettes and lighter in his room potentially resulting in resident injuries and fires. During a review of the facility P&P titled, Smoking Policy - Residents, last reviewed 9/27/2025, the policy indicated, This facility has established and maintains safe resident smoking practices. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 6. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: . a. current level of tobacco consumption; . d. ability to smoke safely with or without supervision (per a completed Safe Smoking Evaluation). 7. The staff consults with the attending physician and the director of nursing services (DNS) to determine if safety restrictions need to be placed on a resident's smoking privileges based on the Safe Smoking Evaluation. 8. A resident's ability to smoke safely is re-evaluated quarterly, upon significant changes (physical or cognitive) and as determined by the staff. 11. Any resident with smoking privileges requiring monitoring shall have (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. 14. Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 9/27/2025, the policy indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. d. During a review of Resident 5's Face Sheet (FS), the FS indicated the facility admitted the resident on 9/22/2025, and readmitted the resident on 6/24/2026, with diagnoses including depression (a serious mental health condition characterized by persistent sadness, low energy, and a loss of interest in activities), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), and aphasia (a disorder that makes it difficult to speak). During a review of Resident 5's H&P, dated 6/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood, sometimes had the ability to understand others, and had moderately impaired vision. The MDS indicated the resident had moderately impaired cognitive skills (a person has noticeable difficulties with thinking, memory, and reasoning that are more severe than normal aging, but not extreme enough to prevent them from living independently). During a review of Resident 5's Fall Risk Evaluation (FRE), dated 6/25/2026, the FRE indicated the resident had intermittent confusion and was at risk for falls. During a review of Resident 5's Care Plan (CP) Report regarding the resident having healthcare deficits related to assistance needed with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily), aging process., last revised on 6/28/2026, the CP indicated an intervention to provide a safe environment. During a concurrent observation and interview on 6/29/2026, at 10:35 a.m., with Certified Nursing Assistant (CNA) 1, inside Resident 5's room, observed Resident 5's bed remote control had frayed wires on them. CNA 1 stated it was not acceptable to have open electrical wires on the resident's equipment or environment as it can cause accidental electrocution on the resident. CNA 1 stated she (CNA 1) will report the issue right away to maintenance to have the bed remote control replaced. During a concurrent interview and record review on 7/1/2026, at 11:20 a.m., with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 5's Medical Diagnoses, FRE, CP, and Policies and Procedures (P&P) were reviewed. The MDS-RN stated it is not okay to have frayed or exposed wires (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on Resident 5's bed remote control because the wires run with electricity and can cause electrical shocks. The MDS-RN stated the maintenance department is responsible for checking the bed for exposed wires and all staff should report if they see exposed electrical wires. The MDS-RN stated the CP regarding the resident having healthcare deficits related to assistance needed with ADLs, aging process., last revised on 6/28/2026, was not followed and the P&P titled Safety and Supervision of Residents, last reviewed on 9/27/2025, was also not followed. During an interview and record review on 7/2/2026, at 11:01 a.m., with the DON, Resident 5's CPs and the facility's P&P were reviewed. The DON stated resident safety is a team effort, if the staff sees any hazards at Resident 5's environment, they should address them promptly to prevent any accidents to happen to the resident. The DON stated having frayed, exposed wires at the resident's environment can lead to fires and accidental electrocution of Resident 5. The DON stated the CP regarding the resident having healthcare deficits related to assistance needed with ADLs, aging process., last revised on 6/28/2026, and the P&P titled, Safety and Supervision of Residents, last reviewed on 9/27/2025, was not followed because they failed to provide a safe environment by having exposed electrical wires on the resident's bed remote control, During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 9/27/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. e. During a review of Resident 48's FS, the FS indicated the facility admitted the resident on 6/7/2026, with diagnoses including difficulty in walking, lack of coordination, and fall. During a review of Resident 48's H&P, dated 6/9/2026, the H&P indicated the resident was admitted to the facility after a fall at home with right distal femur fracture (a break in the lower part of the thigh bone (femur) right above the knee joint). The H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 48's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood, sometimes had the ability to understand others, and had moderately impaired vision. The MDS indicated the resident had severely impaired cognitive skills (a person has lost their ability to think, remember, or make decisions so deeply that they can no longer live independently or safely care for themselves without daily supervision). The MDS indicated the resident was dependent on mobility and ADLs. The MDS indicated the resident had a fall on admission and had fracture (break in bone). During a review of Resident 48's Order Summary Report (OSR), dated 6/7/2026, the OSR indicated an order for low bed (11 inches or less and can be low, ultra-low, or Japanese style) with bilateral upper side rails up (metal or plastic bars attached to the sides of a bed) with bilateral floor mats (a cushioned floor pad designed to help prevent injury should a person fall) to decrease potential injury due to unpredictable movement related to acute encephalopathy (a sudden state of temporary brain malfunction) every shift. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 48's FRE, dated 6/8/2026, the FRE indicated the resident had 1-2 falls in the past three (3) months and was at risk for falls. During a review of Resident 48's CP Report titled, Resident is at risk for falls/injury related to aging process, limited mobility, cognitive impairment., last revised on 6/17/2026, the CP indicated an intervention to provide resident with a safe and clutter-free environment. During a concurrent observation and interview on 6/29/2026, at 9:42 a.m., with the Infection Preventionist (IP), inside Resident 48's room, observed Resident 48 had bilateral floor mats and the right floor mat had a side table on top of them. The IP stated there should be no furniture or equipment on top of Resident 48's floor mat as it can cause accidents with injury when the resident falls on them. During a concurrent interview and record review on 7/1/2026, at 12:02 p.m., with the MDS-RN, Resident 48's Medical Diagnoses, OSR, FRE, CP, and Policies and Procedures (P&P) were reviewed. The MDS-RN stated Resident 48's floor mat should not have any equipment or furniture on top of them as it defeats the purpose of having a safe, soft landing floor mat at the resident's bedside. The MDS-RN stated it is not okay to have equipment or furniture on top of the floor mat because if the resident rolls down from the bed the resident will land on the metal foot of the bedside table and cause injury such as skin tear and head injury to the resident."Reviewed with the MDS-RN the CP titled Resident is at risk for falls/injury related to Aging process, limited mobility, cognitive impairment., last revised on 6/17/2026, and the facility's P&P titled, Safety and Supervision of Residents, and Falls and Fall Risk, Managing, last reviewed on 9/27/2025. The MDS-RN stated the CP and P&Ps were not followed because they were not able to provide a hazard free environment to the resident by placing an equipment on top of the resident's floor mat and was not able to identify the hazard that they placed on the resident's floor mat. During a concurrent interview and record review on 7/2/2026, at 11:01 a.m., with the DON, reviewed Resident's CP, the facility's recent P&Ps, and the facility-provided information on the use of Floor Mat (FM) 1. The DON stated the purpose of the floor mat was to reduce the injury should a resident fall from the bed. The DON stated placing a furniture or equipment on top of the floor mat defeats the purpose of providing a soft-landing surface for the resident and can lead to falls with injury such as skin tear, abrasion, bumps, or even fracture. The DON stated all staff were responsible for ensuring Resident 48's environment was safe, clean, and hazard free, if they identify hazards in the resident's environment they should report them to the appropriate department as soon as possible. The DON stated the failure of the staff to ensure there was no equipment or furniture on top of Resident 48's floor mat had predisposed the resident to		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of two sampled residents (Residents 5 and 38) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq- beneath the skin) insulin administration sites. The deficient practices had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: 1. During a review of Resident 5's Face Sheet (FS), the FS indicated the facility admitted the resident on 9/22/2025, and readmitted the resident on 6/24/2026, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and dysphagia (difficulty swallowing). During a review of Resident 5's History and Physical (H&P), dated 6/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/3/2026, the MDS indicated the resident sometimes had the ability to make self-understood, sometimes had the ability to understand, and had moderately impaired vision. The MDS indicated the resident had moderately impaired cognition (a noticeable decline in memory, language, or focus that is worse than normal aging, but not yet severe enough to cause full dependency) and was on a high-risk drug class hypoglycemic medication (prescription drugs used to lower blood sugar levels). During a review of Resident 5's Order Summary Report (OSR), dated 6/24/2026, the OSR indicated an order for: -Insulin Glargine-yfgn Subcutaneous Solution (Insulin Glargine-yfgn- a type of insulin). Inject 10 units (a specific measurement of how much insulin is needed to lower the blood sugar) subcutaneously at bedtime for DM. Rotate injection site. - Insulin Lispro Injection Solution 100 units per milliliter (unit/ml, how many units of insulin are packed into every 1 milliliter (mL) of liquid) (Insulin Lispro) Inject as per sliding scale (a flexible dosing method where the amount of insulin taken before a meal or at bedtime slides up or down based on the current blood sugar level): if 60 - 150 = 0 unit; 151 - 200 = 2 units; 201 - 250 = 4 Units; 251 - 300 = 6 Units; 301 - 350 = 8 Units; 351 - 400 = 12 units, subcutaneously every 6 hours for Type 2 DM. Notify MD for blood sugar (BS) greater than (>) 400, BS less than (<) 60. May give orange juice (OJ) (8 ounces [oz, a standard unit of measurement]) or glucose gel (a flexible dosing method where the amount of insulin you take before a meal or at bedtime slides up or down based on your current blood sugar level) orally (PO) if BS below 60 milligrams per deciliter (mg/dl, is simply a medical unit of measurement used in the U.S. to tell you how much sugar (glucose) is floating around in a specific amount of your blood). Hold insulin if meals will be skipped. Administer insulin no longer than 5-10 minutes prior to meal or immediately after a meal or with food. Rotate sites. - Semaglutide (0.25 or 0.5 mg/DOS) Subcutaneous Solution Pen-injector 2mg/3 milliliter (ml, a unit of volume) (Semaglutide) Inject 0.5 mg subcutaneously one time a day every Wednesday for type two DM (rotate injection site). During a review of Resident 5's (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan (CP) Report titled, Resident is at risk for hypoglycemia (low blood sugar) and hyperglycemia related to DM, last revised on 5/22/2026, the CP indicated an intervention to administer medications as ordered. During a review of Resident 5's Location of Administration Report (LAR) of Insulin for 4/2026 to 6/2026, the LAR indicated: - Insulin Lispro Injection Solution 100 unit/ml was administered on: 4/3/2026 at 6:10 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 4/4/2026 at 5:16 a.m. on the Abdomen - LLQ 4/16/2026 at 6:12 p.m. on the Abdomen - LLQ 4/17/2026 at 5:08 p.m. on the Abdomen - LLQ 4/18/2026 at 5:42 a.m. on the Abdomen - LLQ 5/1/2026 at 6:58 p.m. on the Abdomen - LLQ 5/2/2026 at 5:26 a.m. on the Abdomen - LLQ 5/4/2026 at 6:59 p.m. on the Abdomen - Right Upper Quadrant (RUQ) 5/5/2026 at 6:55 p.m. on the Abdomen - RUQ 5/9/2026 at 5:46 p.m. on the Abdomen - Left Upper Quadrant (LUQ) 5/10/2026 at 8:24 a.m. on the Abdomen - LUQ 6/25/2026 at 12:10 a.m. on the Abdomen - Right Lower Quadrant (RLQ) 6/25/2026 at 6:41 p.m. on the Abdomen - RLQ - Insulin Glargine Solostar Subcutaneous Solution Pen-injector 100 unit/ml was administered on: 5/9/2026 at 8:45 p.m. on the Abdomen - LUQ 5/10/2026 at 9:26 p.m. on the Abdomen - LUQ During a concurrent interview and record review on 7/1/2026, at 11:56 a.m., with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 5's Medical Diagnoses, OSR, CP, LAR, and policy and procedure (P&P) were reviewed. The MDS-RN stated the site of insulin administration should be rotated to prevent lipodystrophy for Resident 5. The MDS-RN stated the LAR indicated there were multiple instances that the licensed nurses did not rotate the insulin sites of administration on the resident. The MDS-RN stated there were orders to rotate sites of administration meaning the insulin site should be rotated per quadrant of the site selected, for example if it is given on right lower quadrat (RLQ) of the abdomen, it should not be given again on RLQ on the next scheduled administration to prevent repeated injection sites since there was no marker that could definitely show where the last abdominal RLQ site was given. The MDS-RN stated that not rotating insulin administration sites of insulin was considered a medication error because they did not follow the physician's order, manufacturer's specification, and the professional practice of the licensed nurse to rotate insulin sites of administration. The MDS-RN stated the facility's definition of a medication error includes the above-mentioned elements. The MDS-RN stated the licensed staff did not follow the facility's P&P titled, Insulin Administration, last reviewed on 9/27/2025, Adverse Consequences, Medication Errors and Unnecessary Medication, last reviewed on 9/27/2025, and the facility-provided information regarding the resident's ordered insulin by failing to rotate insulin administration sites. During a concurrent interview and record review on 7/2/2026, at 11:01 a.m., with the Director of Nursing (DON), reviewed the facility's P&P on Insulin Administration, Adverse Consequences, Medication Errors and Unnecessary Medication and the facility provided information regarding Resident 5's Insulin from Drugs.com (the internet's largest and most popular free encyclopedia for medicines). The DON stated insulin administration sites should be rotated for Resident 5. The DON stated before they administer the insulin medication, they can see the history in the electronic healthcare record in the electronic Medication Administration Record (eMAR) where the last insulin administration site was. The DON stated for example, the licensed nurse administered the insulin on the right upper arm (RUA) of the resident at 6:30 am, the next scheduled dose at 11:30 am, the licensed nurse should administer the insulin at any other site except for RUA to prevent repetition of sites, it is hard to tell where the last administration site was on the same site as there will be no visible mark where the last insulin injection site was given, to ensure insulin administration was not repeated the licensed nurse were mandated to give them on another site not on the same quadrant selected. The DON stated the purpose of rotating insulin administration sites was to prevent hardening of tissue that can potentially affect the absorption of insulin into the body that can lead to (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sherman Oaks Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 14401 Huston St. Sherman Oaks, CA 91423	
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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hyper/hypoglycemia. The DON also stated consistent use of same insulin administration site can potentially cause infection to Resident 5. The DON stated that not rotating insulin administration site is a medication error because the licensed staff did not follow the physician's order, manufacturer's specification and the nurses' professional practice to rotate insulin administration sites. The DON stated the licensed staff failed to follow the P&P titled, Insulin Administration and Adverse Consequences, Medication Errors and Unnecessary Medication, by failing to rotate insulin administration sites. The DON also added the Manufacturer's Specification for the insulin Resident 5 uses were not followed. 2.During a review of Resident 38's FS, the FS indicated the facility admitted the resident on 2/21/2024, and readmitted the resident on 3/8/2024, with diagnoses including type two diabetes mellitus (DM2), protein-calorie malnutrition (a dangerous condition that occurs when your body does not get enough protein or calories (energy) to function properly), and dysphagia. During a review of Resident 38's H&P, dated 10/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 38's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and usually understand others and had intact cognition (a person's brain functions normally in processing information, without significant impairment to memory, reasoning, or judgment). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication.During a review of Resident 38's OSR, the OSR indicted an order for: 1/25/2025 Admelog SoloStar Subcutaneous Solution Peinjecto100 unit/ml (Insulin Lispro). Inject five units subcutaneously before meals for DM 2. Rotate Injection sites; Hold for fasting self-blood sugar (FSBS, it is a fingerstick test measuring the amount of sugar in the blood after going without food or drink (except water) for at least 8 hours) <100. 5/21/2026 Admelog SoloStar Subcutaneous Solution Pen injector 100 unit/ml (Insulin Lispro) Inject as per sliding scale: if 60 - 150 = 0 units; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units, subcutaneously before meals and at bedtime for DM 2. Notify MD for BS > 400, BS < 60. May give OJ (8oz) or glucose gel PO if BS below 60 mg/dl. Hold insulin if meals will be skipped. Administer insulin no longer than 5-10 minutes prior to meal or immediately after a meal or with food. Rotate sites. 3/17/2026 Lantus SoloStar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 8 units subcutaneously at bedtime for DM. Rotate injection site. Hold for FSBS < 100. 100 unit/ml (Insulin Glargine). Inject 8 units subcutaneously at bedtime for DM. During a review of Resident 38's CP Report titled, Resident is at risk for hypoglycemia and hyperglycemia r/t DM, last revised on 9/25/2024, the CP indicated an intervention to administer medications as ordered. During a review of Resident 38's LAR of Insulin from 4/2026 to 6/2026, the LAR indicated that: -Admelog SoloStar Subcutaneous Solution Pen-injector 100 unit/ml was administered on: 4/16/2026 at 4:45 p.m. in the Abdomen - LUQ 4/17/2026 at 6:51 a.m. in the Abdomen - LUQ 4/20/2026 at 5:28 p.m. in the Abdomen - RLQ 4/26/2026 at 9:04 p.m. in the Abdomen - RLQ 5/04/2026 at 9:41 p.m. in the Abdomen - RUQ 5/05/2026 at 9:57 p.m. in the Abdomen - RUQ 5/09/2026 at 4:52 p.m. in the Abdomen - RUQ 5/10/2026 at 4:46 p.m. in the Abdomen - RUQ 6/11/2026 at 7:16 a.m. in the Abdomen - RLQ 6/11/2026 at 12:48 p.m. in the Abdomen - RLQ 6/11/2026 at 5:20 p.m. in the Abdomen - LUQ 6/12/2026 at 7:46 a.m. in the Abdomen - LUQ During a concurrent interview and record review on 7/1/2026, at 11:50 a.m., with the MDS-RN, Resident 38's Medical Diagnoses, OSR, CP, LAR, and P&P were reviewed. The MDS-RN stated the site of insulin administration should be rotated to prevent lipodystrophy on Resident 38. The MDS-RN stated the LAR indicated there were multiple instances that the licensed nurses did not rotate the insulin sites of administration on the resident. The MDS-RN stated there were orders to rotate sites of administration meaning the insulin site should be rotated per quadrant of the site selected, for example if it is given on RLQ of the abdomen, it should not be (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	given again on RLQ on the next scheduled administration to prevent repeated injection sites since there was no marker that could definitely show where the last abdominal RLQ site was given. The MDS-RN stated that not rotating insulin administration sites of insulin was considered a medication error because they did not follow the physician's order, manufacturer's specification, and the professional practice of the licensed nurse to rotate insulin sites of administration. The MDS-RN stated the facility's definition of a medication error includes the above-mentioned elements. The MDS-RN stated the licensed staff did not follow the facility's P&P titled, Insulin Administration, last reviewed on 9/27/2025, Adverse Consequences, Medication Errors and Unnecessary Medication, last reviewed on 9/27/2025, and the facility-provided information regarding the resident's ordered insulin by failing to rotate insulin administration sites. During a concurrent interview and record review on 7/2/2026, at 11:01 a.m., with the DON, reviewed the facility's P&P on Insulin Administration, Adverse Consequences, Medication Errors and Unnecessary Medication and the facility provided information regarding Resident 38's Insulin from Drugs.com. The DON stated insulin administration sites should be rotated for Resident 38. The DON stated before they administer the insulin medication, they can see the history in the electronic healthcare record in the eMAR where the last insulin administration site was. The DON stated for example, the licensed nurse administered the insulin on the RUA of the resident at 6:30 am, the next scheduled dose at 11:30 am, the licensed nurse should administer the insulin at any other site except for RUA to prevent repetition of sites, it is hard to tell where the last administration site was on the same site as there will be no visible mark where the last insulin injection site was given, to ensure insulin administration was not repeated the licensed nurse were mandated to give them on another site not on the same quadrant selected. The DON stated the purpose of rotating insulin administration sites was to prevent hardening of tissue that can potentially affect the absorption of insulin into the body that can lead to hyper/hypoglycemia. The DON also stated consistent use of same insulin administration can potentially cause infection to Resident 38. The DON stated that not rotating insulin administration site is a medication error because the licensed staff did not follow the physician's order, manufacturer's specification and the nurses' professional practice to rotate insulin administration sites. The DON stated the licensed staff failed to follow the P&P titled, Insulin Administration and Adverse Consequences, Medication Errors and Unnecessary Medication, by failing to rotate insulin administration sites. The DON also added the Manufacturer's Specification for the insulin Resident 38 uses were not followed. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 9/27/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (insulin Injections via Syringe) 16. Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility's recent P&P titled, Adverse Consequences, Medication Errors and Unnecessary Medication, last reviewed on 9/27/2025, the P&P indicated the interdisciplinary team evaluates medication usage in order to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions (ADRs) and side effects. Adverse consequences shall be reported to the attending physician and pharmacist, and to federal agencies as appropriate. Policy Interpretation and Implementation 2. An adverse consequence is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual's mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. adverse drug/medication reaction; b. side effect; c. medication-medication interaction; or d. medication-food interaction. 4. An unnecessary drug is any drug when use in: excessive dosage, excessive duration, without adequate monitoring, without adequate indication for its use, in the (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	presence of adverse consequences which indicate the dose should be reduced or discontinued. 6. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility-provided Drugs.COM information on the use of Insulin Glargine, last updated on 5/7/2026, the Information indicated insulin can be injected into your upper legs (thigh), upper arms, or stomach area (abdomen). DO not inject into the same place two times in a row. Avoid injecting into skin that is damaged, tender, bruised, pitted, thickened, scaly, or has a scar or hard bump. During a review of the facility-provided Drugs.COM information on the use of Insulin Lispro, last updated on 3/2/2026, the Information indicated to use a different place each time you give an injection. Do not inject into the same place two times in a row. Do not inject into skin that is damaged, tender, bruised, pitted, thickened, scaly, or has a scar or hard bump. During a review of the facility-provided Drugs.COM information on the use of Admelog, last updated on 3/2/2026, the Information indicated to use a different place each time you give an injection. Do not inject into the same place two times in a row. Do not inject into skin that is damaged, tender, bruised, pitted, thickened, scaly, or has a scar or hard bump.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe handling of medications and maintain safe and secure storage by failing to: 1. Label Artificial Tears (eyes drops used to lubricate dry eyes) with the resident's name for two residents (Resident 71 and 40) during the inspection of one of four medication carts (Medication Cart 3/AM) investigated during the Medication Storage and Labeling task. 2. Ensure prepared and unlabeled medications were not stored in the medication cart for two residents (Resident 30 and 19) during the inspection of one of four medication carts (Medication Cart 3/AM) investigated during the Medication Storage and Labeling task. These failures had the potential to result in medications administered to the wrong resident potentially resulting in adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) or cross contamination (the transfer of bacteria or viruses from one person to another). 3. Ensure germicidal disinfectant wipes were not stored in the drawer next to two residents (Resident 13 and 64) medications and unit supply medications during the inspection of two of four medication carts (Medication Cart 3/AM and Medication Cart 2/AM) investigated during the Medication Storage and Labeling task. This failure had the potential to result in accidental poisoning from spilled chemicals. 4. Ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable to one of four medication carts audited for medication storage facility task (Medication Cart 2/AM), by failing to ensure Medication Cart 2 did not have a floor stock bottle of Multivitamins with Minerals without an open date observed during medication pass. This failure had the potential to administer expired/outdated medications to residents that can cause adverse reactions. Findings: 1.a. During a review of Resident 71's admission Record (AR or Face Sheet), the AR indicated that the facility admitted the resident on 1/5/2024 with diagnoses that included unspecified macular degeneration (an eye disease that effects central vision). During a review of Resident 71's Minimum Data Set (MDS - a resident assessment tool), dated 6/5/2026, the MDS indicated the resident had the ability to make herself understood and had the ability to understand others. During a review of Resident 71's Order Summary Report, the Order Summary Report indicated a physician order for Artificial Tears Ophthalmic Solution, Instill one (1) drop in both eyes three times a day for dry eye syndrome, 1 drop to each eye, dated 8/6/2024. 1.b. During a review of Resident 40's AR, the AR indicated that the facility admitted the resident on 2/6/2021 and most recently admitted the resident on 5/27/2026 with diagnoses that included dry eye syndrome of bilateral (both sides) lacrimal glands (tear glands). During a review of Resident 40's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make himself understood and sometimes had the ability to understand others. (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident^40's Order Summary Report, the Order Summary Report^indicated^a^physician order for Artificial Tears Ophthalmic Solution,^Instill one (1) drop in both eyes three times a day for dry eye syndrome, 1 drop to each eye, dated^5/27/2026.^ 1.c.^During a review of Resident^19's AR, the AR indicated that the facility admitted the resident on^9/29/2025^and most recently admitted the resident on^5/20/2026^with diagnoses that included^hypertension (HTN -^high blood pressure),^anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), and^depression^(persistent feelings of sadness and loss of interest that can interfere with daily living).^ During a review of Resident^19's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make herself understood and^usually^had the ability to understand others.^ During a review of Resident^19's Order Summary Report, the Order Summary Report^indicated^physician orders for the following:^^ -^Sertraline HCl^(medication to treat depression)^Oral Tablet 100^milligrams (MG - a unit of measurement)^Give 1 tablet by mouth one time a day for depression^manifested by (m/b)^episodes of crying/ tearfulness for no reason, dated^5/20/2026.^ -^Losartan Potassium-HCTZ^(medication to^treat^HTN)^Oral Tablet 100-25^MG,^Give^1^tablet by mouth one time a day for^HTN, dated 6/17/2026.^ -^Propranolol HCl^(medication to treat HTN)^Oral Tablet 20 MG,^Give^1 tablet by mouth two times a day for^HTN, dated 5/20/2026.^ -^Amlodipine^Besylate^(medication to treat HTN)^Oral Tablet 10 MG,^Give^1 tablet by mouth one time a day for^HTN, dated^5/21/2026.^ 1.d.^During a review of Resident^30's AR, the AR indicated that the facility admitted the resident on^1/15/2026^with diagnoses that included^HTN,^bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs),^and^polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues).^ During a review of Resident 30's MDS, dated [DATE], the MDS indicated the resident^rarely/never^had the ability to make^herself understood and^rarely/never^had the ability to understand others.^ During a review of Resident 30's Order Summary Report, the Order Summary Report^indicated^physician orders^for^the following:^^ -^Divalproex Sodium^(medication to treat bipolar disorder)^Oral Capsule Delayed Release,^Sprinkle 125 MG,^Give1 capsule^by mouth one time a day for Bipolar disorder M/B^rapid or extreme mood (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	swings from manic state^depressed state or vice versa such as elevated mood,^impulsivity then becoming withdrawn and quiet, dated 6/26/2026.^ ^-Folic Acid^(a dietary supplement)^Oral Tablet 1^MG^,^Give^1 tablet^by mouth in the morning for supplement, dated 1/15/2026.^ ^-Lisinopril^(medication to treat HTN)^Oral Tablet 20 MG,^Give^1 tablet^by mouth one time a day for HTN, dated 3/1/2026.^ ^-Acetaminophen^(medication to treat pain)^Tablet 325 MG,^Give^2 tablets^by mouth every 4 hours as needed for^Mild Pain, dated 1/15/2026.^ During a concurrent interview and observation of Medication Cart 3/AM^on 6/30/2026^at^10:55 a.m.^with Licensed Vocational Nurse (LVN) 1,^observed^the following:^^ 1. LVN 1^opened the top right drawer of the cart and^stated^all medication is labeled^to ensure the correct medication is^administered^to the correct resident. LVN 1^stated^the facility^provides house^stock^Artificial Tears^eye drops^that do not^have a pharmacy^label,^so the licensed nurse writes the^residents^name on the box^that^contains^the^residents^eye drops^and the container.^LVN 1^stated^there were two boxes^of^Artificial Tears^that were labeled with^only^the^room numbers^for Resident 31 and Resident 40. LVN 1^stated^the^residents^names were not written on the eye drops, but they should have been. LVN 1^stated^labeling the eye drops with only the room number was not proper labeling because residents^change^rooms and there was the potential for the wrong resident to receive the medication.^ 2. LVN 1 opened the bottom left drawer of the medication cart and noted there^were two^unlabeled^medication cups^containing^resident^medications. LVN 1^stated^one medication cup^contained^Resident^19's^sertraline, propranolol, amlodipine, and losartan. LVN 1^stated^the other^medication cup^contained^Resident 30's^folic acid, acetaminophen,^divalproex^sodium, and lisinopril crushed and mixed with applesauce. LVN1 stated^she (LVN 1) removed Resident 19 and 30's^medications from the bubble^packs^(a package that contains multiple sealed compartments with medication)^and placed them in^the^cups^but the^residents^were not available to take the medication, so she placed them in the medication cart. LVN 1^stated^she should not have stored^prepared and unlabeled medications in the medication cart when the^residents^were not available, but she did.^LVN 1^stated^she did not follow the facility process for medication storage and administration.^ 3. LVN 1 opened the bottom right drawer of the medication cart and stated there was a container of Germicidal Wipes (GM ^pre-moistened, hospital-grade disposable cloths used to kill bacteria^and^viruses^on^non-porous surfaces)^1^directly next to^opened^containers of over the counter^resident^medications including^milk of magnesia^(medication to^treat constipation), antacid tablets^(medication to treat^indigestion),^liquid iron supplement, and^polyethylene glycol^(medication to treat^constipation).^LVN 1 stated^medication and GM^1 should not be placed in the medication cart next^to^each^other, but they were.^ (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 7/2/2026 at 10:08 a.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) titled, Storage of Medications, last reviewed 9/27/2025, was reviewed. The DON stated: - Artificial Tears eye drops need to be labeled with the resident name because the resident's room number may change. The DON stated that when Resident 71 and Resident 40's eye drops were not labeled with the residents' names there was a potential that the wrong medication or wrong resident may be administered the medication resulting in eye infections or allergic reactions in residents. The DON stated the facility P&P was not followed. - The facility process is medications are removed and administered for one resident at a time and unlabeled prepared medications are never stored in the medication cart. The DON stated if a resident is not available for medication administration, then the prepared medications are discarded, and the nurse should remove new medications when the resident is available to prevent the wrong medication from being administered to the wrong resident. The DON stated when LVN 1 prepared and stored unlabeled medications for Residents 19 and 30, the facility P&P was not followed potentially resulting in medication errors including allergic reactions, hypotension (low blood pressure), overdose, and other adverse effects. - Disinfectant wipes are stored in medication carts in a drawer that does not contain resident medications because chemicals may leak or spill contaminating the medication in the drawer resulting in adverse effects in residents like poisoning. The DON stated the P&P was not followed when GW 1 was stored in Medication Cart 3/AM with resident medications. During a review of the facility's P&P titled, Medication Ordering and Receiving from Pharmacy, last reviewed 9/27/2025, the P&P indicated, Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels. A. Labels are permanently affixed to the outside of the prescription container. No medication is accepted with the label inserted into a vial. If a label does not fit directly onto the product, e.g., eye drops, the label may be affixed to an outside container or carton, but the resident's name, at least, must be maintained directly on the actual product container. During a review of the facility's P&P titled, Storage of Medications, last reviewed 9/27/2025, the P&P indicated, The Facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals are store in the packaging, containers or other dispensing systems in which they are received. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. 2.a. During a review of Resident 64's AR, the AR indicated the facility originally admitted the resident on 11/18/2020 and readmitted on [DATE], with diagnoses including Epilepsy, unspecified, not intractable, without status epilepticus (a seizure [a sudden, uncontrolled burst of electrical activity in the brain that can cause changes in behavior, awareness, or feelings] disorder that is controlled or treatable, with no ongoing prolonged seizures); essential (primary) hypertension; hyperlipidemia, unspecified (high levels of fat in the blood). (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sherman Oaks Health & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 14401 Huston St. Sherman Oaks, CA 91423	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64's H&P, dated 6/1/2026, the H&P indicated the resident does not have the capacity to understand and make decisions.^^ 2.b. During a record review of Resident 13's AR, the AR indicated the facility originally admitted the resident on 2/22/2021 and readmitted on [DATE], with diagnoses including generalized muscle weakness, dysphagia, oropharyngeal phase (starts in the mouth and cannot swallow properly at the beginning, so food or drink does not go down smoothly), other seizures.^^ During a review of Resident 13's H&P, dated 5/18/2026, the H&P indicated the resident does not have the capacity to understand and make decisions.^^ During a concurrent observation and interview on 6/30/2026 at 2:40 p.m. with LVN 2, while checking medication cart 2/AM, observed in the left bottom drawer of the cart there were medications and a container of GM next to each other. The germicidal wipes container was on its side and spilled in medication cart drawer. LVN 2 stated there was a puddle of liquid under the container in a yellow medication tray in the drawer. LVN 2 stated no chemicals should be mixed with medication. LVN 2 stated the germicidal wipes solution can potentially ruin the medications, contaminate medications, and potentially cause side effects to the residents. LVN 2 stated the residents' reaction can be different and can potentially be toxic to them.^^ During an interview on 7/2/2026 at 10:08 a.m. with the DON, the DON stated disinfectant wipes are stored in medication carts in a drawer that does not contain resident medications because chemicals may leak or spill contaminating the medication in the drawer resulting in adverse effects in residents like allergies or poisoning. The DON stated the P&P titled, Medication Storage in the Facility, was not followed when germicidal wipes were stored in Medication Cart 2/AM with resident medications.^^^ During a review of the facility P&P titled, Medication Storage in the Facility, last reviewed 9/27/2025, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturers recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. The provider pharmacy dispenses medications in containers that meet legal requirements, including standards set forth by the United States Pharmacopeia (USP - an independent, non-profit scientific organization that sets quality, purity, strength, and identity standards for medicines, dietary supplements, and food ingredients). Medications are kept in these containers. Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies; disinfectants are clearly identified and stored in a locked area separately from medications.^^ During a review of the facility provided GW 1 manufacture guidelines, dated 2023, the GW 1 manufacture guidelines indicated, [GW 1] is a durable polypropylene cloth that features a quaternary ammonium and alcohol solution (chemicals used as disinfectants) to kill 25 microorganisms.^^ During a review of GW 1 Safety Data Sheet, dated 10/23/2023, the GW 1 Safety Data Sheet indicated, Conditions for safe storage, including any incompatibilities: . Store away from incompatible materials. Section 11. Toxicological Information. Ingestion: May cause stomach distress, nausea or vomiting.^^ (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 116's AR, the AR indicated the facility admitted the resident on 10/14/2022, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild to moderate muscle weakness on one entire side of the body) and narcolepsy (a chronic brain disorder that disrupts your ability to control sleep and wakefulness).^ During a review of Resident 116's H&P, dated 10/5/2025, the H&P^indicated^the resident did not have the capacity to understand and make decisions.^ During a review of Resident 116's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderately impaired cognition (a person has a noticeable decline in their ability to think, remember, or reason).^ During a review of Resident 116's Order Summary Report (OSR), dated 10/14/2022, the OSR indicated an order for Multivitamin with Mineral. Give 1 tablet by mouth one time a day for supplement.^ During a concurrent observation and interview on 7/1/2026 at 8:15 a.m. with LVN 2, in front of Resident 116's room, observed LVN 2 prepare morning medications for Resident 116. LVN 2 stated Medication Cart 2/AM is used to pass Resident 116's medications. Observed LVN 2 take a floor stock opened bottle of Multivitamin with Mineral in Medication Cart 2/AM with^expiration^date of 5/2027 without an open date. LVN 2^stated^the floor stock bottle of Multivitamin with Mineral^has to^have an open date just like food we need to know if it is expired or how long it has been opened.^ During a concurrent interview and record review on 7/1/2026 at 12:28 p.m. with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 116's Medical Diagnoses and OSR were reviewed. The MDS-RN^stated^every bottle of floor stocks should have an open date to ensure the medication is not more than 30 days when opened. The MDS-RN^stated^medication could be stale or expired already.^ During a concurrent interview and record review on 7/2/2026 at 11:02 a.m. with the DON, the facility's recent P&P titled, Procedures for All Medications, last reviewed 9/27/2025, was reviewed. The DON^stated^once staff open the floor stock medications, they should have^an^date open because that is^an indication^of when that actual medication was opened. The DON^stated^the failure of the staff to place an open date on floor stock medications had the potential for using the medication more than it was intended to be used. The DON^stated^the P&P titled, Procedures for All Medications, was not followed by the staff^failing to place^an open date on multidose medication container.^ During a review of the facility's recent P&P titled, Procedures for All Medications, last reviewed on 9/27/2025, the P&P^indicated^to administer medications in a safe and effective manner.^ Procedures^ E. Check^expiration^date on package/container. When opening multi-dose container, place the date on the container.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to properly document medical records for one (1) of three sampled resident (Resident 8) by failing to accurately document the Metoprolol (a prescription medication that slows down the heart rate and relaxes the blood vessels) in the Medication Administration Record (MAR - a list of scheduled medications and other instructions ordered by the medical director) was held but was documented as given on 6/14/2026, 6/15/2026, and 6/27/2026. These failures had the potential to result in incomplete, inaccurate, or delayed records that could lead to miscommunication between healthcare providers and resident harm. Findings: During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted the resident on 4/24/2026, with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), hypertension (HTN - high blood pressure), sleep apnea (a breathing disorder where breathing repeatedly stops and starts while you sleep, and depression (an overwhelming, persistent feeling of sadness, hopelessness, or numbness that lasts for weeks). During a review of Resident 8's History and Physical (H&P), dated 4/30/2026, the H&P indicated the resident is not having memory loss and has the capacity to make medical decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 5/5/2026, the MDS indicated the resident had moderate cognitive impairment (meaning the individual's cognition is borderline intact but they show signs of mental decline and the resident was requiring partial/moderate assistance (helper does less than half the effort) with eating, substantial/maximal assistance (helper does more than half the effort) with oral and personal hygiene, and dependent with toileting hygiene, shower/bathe self and transfers. During a review of Resident 8's Order Summary Report (OSR - also known as Physician's Order), dated 4/27/2026, the Order Summary Report indicated an order for Metoprolol Succinate ER Oral Tablet Extended Release 24-hour 25 milligram (mg - a unit of measure for mass), Give 1 tablet by mouth one time a day for Essential hypertension with parameters to hold for systolic blood pressure (SBP - the top or first number in a blood pressure reading) less than 110 or heart rate less than 60. Give with food. During a review of Resident 8's Care Plan titled, Resident is at risk for cardiac distress related to: ESRD with HTN, (.), on Metoprolol succinate, at risk for: shortness of breath, chest pain, irregular pulse, dizziness (.), hypotension (it means the force of the blood pushing against the artery walls is lower than normal, which can sometimes mean the heart, brain and other organs are not getting enough oxygen-rich blood), altered mental status, headache, initiated on 4/27/2026, with goal indicating the resident will have no unrecognized signs and symptoms of cardiac distress daily until the next assessment, and interventions including to observe for headache, chest pain, irregular pulse, edema, shortness of breath, elevated blood pressure, dizziness, hypotension, fatigue, weakness, diaphoresis, and altered mental status and report to medical doctor (MD) promptly; monitor pulse rate and BP as ordered; and assess for s/s of hypotension. The CP titled, Falling Star Program, initiated on 5/08/2026 indicated the resident is at risk for falls related to: Antihypertensive medications (.) with a goal indicating the resident will reduce risk of falls and/or injury thru appropriate intervention(s) daily until the next assessment. During a concurrent interview and record review on 7/1/2026 at 8:39 a.m. with the Infection Prevention nurse (IP), Resident 8's MAR, dated 6/14/2026, 6/15/2026, and 6/27/2026 were reviewed. The IP stated that before giving any medications to a resident aside from observing the five rights (to ensure that the correct medication is given to the intended person in the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	correct way), nurses need to check the order, if there are any parameters, and assess the resident. The IP nurse stated Resident 8 has an order for Metoprolol succinate 25 mg to be given daily at nine (9) a.m. with parameters to hold medication for SBP less than 110 or hear rate less than 60. The IP nurse stated when SPB is below 110, the medication must be held and documented as 5 which means to hold the medication and provide an explanation in the progress notes and document nurses' initials on the Medication Administration Record. The IP nurse further stated that if the BP and HR are more than the parameters, a check mark (meaning the medication was given) with nurses' initials are documented. The IP nurses stated metoprolol was documented as given, with BP readings on the following dates: 6/14/2026 BP 102/63, 6/15/2026 105/65, and 6/27/2026 102/58. The IP nurse stated it was his initials showing on two of the dates. The IP nurse stated it was likely a documentation error and further stated that he was certain the medication had not been administered. The IP nurse stated it is important to document accurately as it serves as proof whether the medication was given or not. The IP nurse further stated that administering the medication with low BP, could increase the risk of hypotension for the resident. During a concurrent interview and record review on 7/1/2026 at 10:56 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the parameters are established to ensure medication is withheld if blood pressure readings are low. The ADON stated that documentation indicated the medication was administered, which could have placed the resident at risk for hypotension. The ADON stated documentation is very important because if it showed that the medication was held, it can inform healthcare professionals' decision regarding dose reduction or discontinuation of the medication. During an interview on 7/2/2026 at 12:06 p.m. with the Director of Nursing (DON), the DON stated an order with parameters as a basis whether to give the medication or be held depending on the blood pressure readings. The DON stated that the IP nurse had signed the medication as given in the MAR but was unable to confirm whether the medication had actually been given. The DON stated that medication documentation is very important because it enables physicians to monitor the need for adjustments, particularly regarding blood pressure medication for Resident 8, who is undergoing dialysis. The DON stated that the policy and procedure (P&P) on charting and documentation was not followed. During a review of the facility's recent P&P titled, Charting and Documentation, last reviewed on 9/27/2025, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy and Interpretation and Implementation 1. Documentation in the medical record may be electronic, manual or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medication administered; c. Treatments and services performed; d. Changes in the resident's condition; e. Events, incidents, or accidents involving the resident, and; f. Progress toward or changes in the care plan goals and objectives. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 6. To ensure consistency in charting and documentation of the resident's clinical record, only facility approved abbreviations and symbols may be used when recording entries I the resident's clinical records. 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time of the procedure/treatment was provided; b. the name and title of the individual(s) who provided the care; c. the assessment data and/or any unusual findings obtained during the procedure/treatment; d. how the resident tolerated the procedure/treatment; e. whether the resident refused the procedure/treatment; g. the signature and title of the individual documenting.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the electrical and resident care equipment were in safe operating condition for three of six sampled residents (Residents 38, 53, and 63) reviewed under environmental task by failing to: 1. Ensure Resident 38 and 53 did not have any frayed wires on the residents' bed remote controls (handheld devices that allow residents or caregivers to adjust the position of a motorized medical bed).^ 2. Ensure Resident 63's bedside electric fan did not have dust build-up on the fan blades and protective grill. These failures had the potential for Residents 38, 53, and 63 to sustain accidents such as electrical shock, physical discomforts, and upper respiratory tract infection (URI, a common, usually mild, contagious illness that affects the upper part of your breathing system, which includes the nose, sinuses, pharynx [throat], and larynx [voice box]). Findings: 1a. During a review of Resident 38's Face Sheet (FS), the FS indicated the facility admitted the resident on 2/21/2024, and readmitted the resident on 3/8/2024, with diagnoses including cerebral infarction (the death of brain tissue caused by a lack of blood flow) and history of falling. During a review of Resident 38's History and Physical (H&P), dated 10/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 6/16/2026, the MDS indicated the resident had the ability to make self-understood, usually understand others, and had impaired vision. The MDS indicated the resident had intact cognition (a person's mental abilities-such as memory, attention, language, and problem-solving-are functioning normally without any significant impairment or decline). During a review of Resident 38's Fall Risk Evaluation (FRE), dated 6/30/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 38's Care Plan (CP) Report titled, Resident has impaired visual functioning (sees large prints) related to: Aging, related to r/t minimally conscious state (MCA, is a condition of severely altered consciousness where a patient demonstrates minimal, but clear and definite, signs of awareness of themselves or their environment) with left hemiparesis (partial weakness or reduced muscle control affecting the entire left side of the body), history (hx) of traumatic brain hemorrhage (bleeding inside or around the brain caused by an external physical force, such as a fall, car crash, or sports injury) related to hx of hemorrhagic stroke (bleeding inside or around the brain caused by an external physical force, such as a fall, car crash, or sports injury), diabetes (a chronic condition where your body's blood sugar (glucose) levels are too high), presbyopia (the natural, age-related loss of the eye's ability to focus on nearby objects), myopia (the natural, age-related loss of your eye's ability to focus on nearby objects), cataract (the natural, age-related loss of your eye's ability to focus on nearby objects), last revised on 3/26/2026, the CP indicated an intervention to provide a safe environment, free of hazards. During a concurrent observation and interview on 6/29/2026, at 9:51 a.m., with Licensed Vocational Nurse (LVN) 3, inside Resident 38's room, observed Resident 38's bed remote control with frayed wires on them. LVN 3 stated there should be no open wires on the resident's environment due to potential for accidents such as electrocution and the bed might not work properly. During a concurrent interview and record review on 7/1/2026, at 11:50 a.m., with the Minimum Data Set- Registered Nurse (MDS-RN), reviewed Resident 38's Medical Diagnoses, FRE, and CP. The MDS-RN stated it was not okay to have exposed electrical wires at the resident's environment as it can cause accidents such as electrical shocks. The MDS-RN stated the maintenance department was responsible for ensuring there were no frayed/open wires at the resident's environment and all staff were mandated to report hazards in the resident's environment to (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate departments. The MDS-RN stated the care plan titled, Resident has impaired visual functioning (sees large prints) related to: Aging, r/t MCA with left hemiparesis, hx of traumatic brain hemorrhage., was not followed by the facility by failing to provide a safe environment, free of hazards. During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the Director of Nursing (DON), reviewed the facility's P&P titled, Maintenance Service. The DON stated there should be no frayed wires on Resident 38's room as it can cause accidents such as electrical shocks. The DON stated it was a joint effort between the staff and maintenance department to ensure there are no hazards at the resident's environment. The DON stated the staff should report to maintenance department if they see hazards at the resident's environment such as exposed electrical wires. The DON stated the P&P titled, Maintenance Service, was not followed by failing to ensure that the equipment in the facility was in a safe and operable manner at all times. 1b. During a review of Resident 53's FS, the FS indicated the facility admitted the resident on 5/7/2026, with lack of coordination, generalized anxiety disorder (GAD, a mental health condition characterized by chronic, excessive, and uncontrollable worry about everyday things like health, money, or work), and depression (a serious mood disorder that causes persistent sadness and a loss of interest in activities they usually enjoy). During a review of Resident 53's H&P, dated 5/8/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 53's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (the medical stage of brain decline where memory, reasoning, or judgment issues become noticeable enough to disrupt daily independence and require some daily assistance). During a review of Resident 53's CP Report titled, Resident has self-care deficits related to (r/t) assistance needed with activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily) (mod to dependent), aging process, limited mobility., last revised on 5/18/2026, the CP indicated an intervention to provide a safe environment. During a concurrent observation and interview on 6/29/2026, at 9:55 a.m., with LVN 3, inside Resident 53's room, observed Resident 53's bed remote control with frayed wires on them. LVN 3 stated there should be no open wires on the resident's environment due to potential for accidents such as electrocution and the bed might not work properly. During a concurrent interview and record review on 7/1/2026, at 11:50 a.m., with the MDS-RN, reviewed Resident 53's Medical Diagnoses, and CP. The MDS-RN stated it was not okay to have exposed electrical wires at the resident's environment as it can cause accidents such as electrical shocks. The MDS-RN stated the maintenance department was responsible for ensuring there were no frayed/open wires at the resident's environment and all staff were mandated to report hazards in the resident's environment to appropriate departments. The MDS-RN stated the care plan titled, Resident has self-care deficits r/t assistance needed with ADLs (mod to dependent), aging process, limited mobility., was not followed by the facility failing to provide a safe environment, free of hazards. During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the DON, reviewed the facility's P&P titled, Maintenance Service. The DON stated there should be no frayed wires on Resident 53's room as it can cause accidents such as electrical shocks. The DON stated it was a joint effort between the staff and maintenance department to ensure there are no hazards at the resident's environment. The DON stated the staff should report to maintenance department if they see hazards at the resident's environment such as exposed electrical wires. The DON stated the P&P titled, Maintenance Service, was not followed by failing to ensure that the equipment in the facility was in a safe and operable manner at all times. 2. During a review of Resident 63's FS, the FS indicated the facility admitted the resident on 7/3/2018, and readmitted the resident on 8/11/2025, with diagnoses including dementia (continued on next page)		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(a progressive state of decline in mental abilities) and functional quadriplegia (a person is completely unable to move all four limbs or the torso, not because of a severed spinal cord, but due to severe overall frailty or an advanced condition like end-stage dementia, severe multiple sclerosis, or advanced muscular atrophy). During a review of Resident 63's H&P, undated, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and rarely to never had the ability to understand others and had severely impaired cognitive skills (a person has lost their mental capacity so profoundly that they can no longer live independently or manage basic daily tasks without substantial daily supervision). During a concurrent observation and interview on 6/29/2026, at 9:55 a.m., with Certified Nursing Assistant (CNA) 9, inside Resident 63's room, observed Resident 63's bedside electric fan running with the fan blades and the protective grill with dust build up. CNA 9 stated the fan was not clean and had dust build up. CNA 9 stated it was not okay to have dust build up on the fan as it can cause respiratory allergies and spread dust mites (microscopic, insect-like pests related to spiders and ticks). During a concurrent interview and record review on 7/1/2026, at 12:06 p.m., with the MDS-RN, reviewed Resident 63's Medical Diagnoses, H&P, MDS, and policy and procedure (P&P). The MDS-RN stated Resident 63's bedside electric fan should be free from dust build up at all times to prevent URI on residents. The MDS-RN stated it was the responsibility of the maintenance department to ensure the equipment in the facility are in good, clean, and working condition. The MDS-RN stated the staff should report dirty equipment such as electric fans, and other equipment attached to the resident to the maintenance department to ensure it is clean and safe to use. The MDS-RN stated the facility did not follow their P&P titled, Maintenance Service, by failing to ensure the electric fan was free from dust build up. During an interview and record review on 7/2/2026, at 11:02 a.m., with the DON, reviewed the facility's P&P titled, Maintenance Service. The DON stated Resident 63's fan should not have dust build up as it can cause the resident to develop allergies, infection, and respiratory problems. The DON stated the housekeeping is responsible for keeping the fans clean, however, the staff should report to housekeeping every time they see equipment or furniture at the resident's surroundings that needed to be cleaned. The DON stated the staff in the facility should ensure every time they provide care or services to the resident to check the environment of the residents for hazards, cleanliness and functional equipment and appliances. The DON stated the facility did not follow the P&P titled, Maintenance Service, by failing to ensure the equipment (the fan) was not kept clean inside Resident 63's room. During a review of the facility's recent P&P titled, Maintenance Service, last reviewed on 9/27/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. Policy Interpretation and Implementation 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: d. maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order.		

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free from the use of unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic medications (any medication capable of affecting the mind, emotions, and behavior) in accordance with the facility policy and procedure by failing to: 1. Ensure as needed (PRN) lorazepam (a psychotropic medication use to treat feelings of anxiousness) physician orders included a stop date (indicates when medication will no longer be administered or dispensed directed by the prescriber) on 3/12/2026 and 6/22/2026 for one of one sampled residents (Residents 83) reviewed for Hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility). 2. Ensure the facility obtained an informed consent (IC, a voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) on the use of Klonopin Oral Tablet (the brand name for clonazepam, is a powerful prescription tranquilizer used to calm an overactive nervous system) 0.5 milligrams (mg, a unit of weight). Give 0.5 tablet by mouth two times a day for anxiety (the body's natural response to stress, presenting as feelings of nervousness, worry, or fear about future events) for one of five sampled residents (Resident 74) reviewed for Unnecessary Medications. These deficient practices had the potential to result in the use of unnecessary psychotropic drugs and adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery). Findings: a. During a review of Resident 83's admission Record (AR or Face Sheet), the AR indicated the facility admitted the resident on 3/2/2026 with diagnoses including cirrhosis of liver (permanent scarring that damages the liver [organ that removes toxins from the body's blood supply), anxiety disorder (a mental health condition that may result in restlessness, irritability, feelings of nervousness, panic, and fear), [NAME] encephalopathy (a severe neurological disorder caused by thiamine [vitamin B1] deficiency), and traumatic brain injury (TBI-a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head). During a review of Resident 83's History and Physical (H&P), undated, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 83's Minimum Data Set (MDS, resident assessment tool), dated 6/12/2026, the MDS indicated the resident usually had the ability to understand others and usually had the ability to make herself understood. The MDS further indicated the resident received high risk, antianxiety drugs while in the facility. During a review of Resident 83's physician orders, the physician's orders indicated orders for the following: - Lorazepam Oral Tablet 0.5 milligrams (MG &ndash; a unit of measurement), Give one (1) tablet by mouth every six (6) hours as needed for anxiety manifested by (M/B) restlessness / terminal agitation leading to shortness of breath, dated 6/22/2026, stop date: indefinite. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lorazepam oral tablet 0.5 MG, give one tablet by mouth every six (6) hours PRN anxiety M/B panicky feelings causing agitation/shortness of breath, no stop date, dated 3/12/2026 and discontinued 5/11/2026. During a review of Resident 83's Care Plan (CP) titled, ANXIETY, Resident has periods of anxiety. medication Lorazepam. At risk for side effects. resident is on hospice., initiated 3/3/2026, the CP indicated a goal to minimize the risk of adverse side effects of medication with interventions that included a monthly pharmacy drug review. During a review of Resident 83's Consultant Pharmacist's Medication Regimen Review (MRR), dated 3/18/2026, the MRR indicated Resident 83 had an order for PRN lorazepam and Centers for Medicare and Medicaid Services (CMS - a federal agency) regulations state that PRN orders for psychotropic drugs are limited to 14 days except if the attending physician believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale and indicate the duration for the PRN order. The duration should be the length of time between initial evaluation that the physician decides PRN therapy is needed until the next date that the physician intends to re-evaluate therapy, cannot be left as indefinite duration. The MRR facility follow through column of the form indicated Patient is a Hospice patient. During a concurrent interview and record review on 7/1/2026 at 9:37 a.m. with the MDS Registered Nurse (MDS-RN), Resident 83's physician orders, MRR, and medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) from 3/2026 to 6/2026 were reviewed. The MDS-RN stated all psychotropic medications ordered to be administered PRN must have a stop date. The MDS-RN stated PRN psychotropic medications have a lot of side effects and must be re-evaluated by the physician to ensure there is an ongoing need for the medication. The MDS-RN stated if a PRN psychotropic is ordered without a stop date and the resident is not re-evaluated then it is considered unnecessary psychotropic medication. The MDS-RN stated the facility obtained an order for lorazepam PRN on 3/12/2026 with an indefinite stop date and was not discontinued until 5/11/2026. The MDS-RN stated the MRR dated 3/18/2026 indicated Resident 83's PRN lorazepam required a stop date, but the MRR was not followed up on and the PRN lorazepam order indicated an indefinite stop date for two months without a physician's evaluation for the need of the PRN medication. The MDS-RN stated the facility obtained another order for lorazepam PRN on 6/12/2026 with an indefinite stop date. The MDS-RN stated even PRN psychotropic medications for residents on hospice require a stop date, but Resident 83's orders on 3/12/2026 and 6/22/2026 did not include stop dates but they should have. During a concurrent interview and record review on 7/2/2026 at 10:08 a.m., with the Director of Nursing (DON) the DON reviewed Resident 83's physician orders and the facility policy and procedure (P&P) regarding psychotropic medications. The DON stated the facility policy indicates PRN psychotropic medications must have a stop date when a re-evaluation of the PRN medication is to be completed, including residents on hospice. The DON stated when Resident 83 had orders for PRN lorazepam without a stop date, it could have potentially led to the resident being administered unnecessary psychotropic medication with side effects like sedation and dizziness leading to injury from falls. The DON stated the facility P&P was not followed. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed 9/27/2025, the P&P indicated, Residents will not receive medications that are not clinically indicated to treat a specific condition. A psychotropic medication is any medication that affects brain activity associated with mental processes and behavior. Drugs in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: Anti-anxiety medications. Psychotropic medications are not prescribed or given on an as needed (PRN) basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. For psychotropic medications that are NOT antipsychotics: If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration for the PRN order. b. During a review of Resident 74's Face Sheet (FS), the FS indicated the facility admitted the resident on 3/24/2007, and readmitted the resident on 4/1/2026, with diagnoses including anxiety disorder, depression (a serious mental health condition characterized by persistent sadness, low energy, and a loss of interest in activities), and mood disorder (a mental health condition that causes persistent and extreme shifts in your emotional state). During a review of Resident 74's H&P, dated 4/4/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 74's MDS, dated [DATE], the MDS indicated the resident sometimes had the capacity to make self-understood and usually understand others and had moderately impaired cognition (a noticeable decline in mental abilities that interferes with—but does not fully prevent—everyday independence). The MDS indicated the resident was on a high-risk drug class antidepressant (a prescription medication designed to balance brain chemicals called neurotransmitters, which regulate mood and emotions). During a review of Resident 74's Order Summary Report (OSR), dated 6/27/2026, the OSR indicated an order for Klonopin Oral Tablet 0.5 mg (Clonazepam). Give 0.5 tablet by mouth two times a day for anxiety monitor for behavior panicky feeling causing panic attacks. During a review of Resident 74's CP Report titled, Klonopin. At risk for adverse effect from Black Box Med (a prescription drug with the FDA's strictest safety alert) [Klonopin], initiated on 6/27/2026, the CP indicated an intervention of the use of clonazepam, exposes users to risks of abuse, misuse, and addiction, which can lead to overdose or death. During a concurrent interview and record review on 7/1/2026, at 12:14 p.m., with the MDS-RN, Resident 74's Medical Diagnoses, OSR, IC, and CPs were reviewed. The MDS-RN stated she cannot find the IC for Klonopin in the electronic healthcare record and the physical chart. The MDS-RN stated that Klonopin should not have been given to Resident 74 without the informed consent. The MDS-RN stated their failure to obtain an IC prior to the administration of a psychotropic medication had violated the resident's right to informed consent. The MDS-RN also stated that the resident was subjected to the adverse effects of the psychotropic medication, and it has a black box warning. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the DON, facility's recent policy and procedure (P&P) on IC was reviewed. The DON stated the purpose of the IC was to explain the risk and benefits of taking the psychotropic medications and to give time for the resident or representative to agree or to disagree with the proposed treatment which is a resident's right. The DON stated the staff administered psychotropic medication without Resident 74's or the representative's consent which violated the resident's right. The DON stated the failure of the staff to obtain an informed consent had subjected the resident to adverse effects of the medications that the resident/representative had no knowledge of. The DON also stated the licensed staff did not follow the facilities recent P&P titled, Informed Consent as the physician has not signed an informed consent form after explaining all necessary information to the residents or their representatives and the licensed nurses not verifying if there was a consent prior to administration of the psychotropic drug. During a review of the facility's recent P&P titled, Informed Consent, last reviewed on 9/27/2025, the P&P indicated to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints. Procedure: 3. The physician and/or prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives. 4. Informed consent may be obtained through the following means: -In person -By phone -Via fax -By email 10. The informed consent form shall be maintained in the resident's clinical record.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers/injury (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of two sampled residents (Resident 7) reviewed under pressure ulcer/injury by failing to ensure the facility obtained an order for a right heel protector (devices or covers used to either protect your foot from pain and injury or to safeguard the heels of your shoes from wear and tear) that was applied to the resident's right foot with diabetic ulcer (an open sore or wound on the foot caused by complications from diabetes) and right shin vascular ulcer (a slow-healing open sore on the skin caused by poor blood circulation). The deficient practice had the potential for worsening of diabetic foot ulcer or pressure injury to residents. Findings: During a review of Resident 7's Face Sheet (FS), the FS indicated the facility admitted the resident on 5/24/2026, with diagnoses including cellulitis (a skin infection that causes swelling and redness) of right lower limb, peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and pressure ulcer of sacral region (the area at the very bottom of your lower back, right above your tailbone and between your hip bones), stage three (Full-thickness loss of skin. Dead and black tissue may be visible). During a review of Resident 7's History and Physical (H&P), dated 5/26/2026, the H&P indicated the resident had decubitus ulcer stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on the right heel and the resident had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/30/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (the middle ground where a person has noticeable difficulties with thinking, memory, or language that their everyday independence begins to slip). The MDS indicated the resident was mostly dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had pressure injury and was at risk for developing pressure ulcers/injuries. The resident had two unhealed pressure injury stage three and one venous and arterial ulcers that was present on admission. The MDS also indicated the resident was on a pressure reducing device for bed. During a review of Resident 7's Order Summary Report (OSR), the OSR indicated an order for: 5/24/2026 Wound consult PRN (given as needed or requested). 6/22/2026 Santyl External Ointment (a prescription medicine used to clean dead tissue out of severe burns and chronic skin ulcers) 250 units per gram (unit/gm, is a measurement used to express the concentration or potency of a substance, such as a vitamin, medication, or bacterial culture, within a specific mass) (Collagenase). Apply to right (Rt) heel topically (applying a medicine or cream directly to the surface of a specific, localized part of the body (like skin, eyes, or a specific muscle) every day shift for diabetic ulcer for 30 Days. Cleanse with normal saline solution (NSS, a simple, sterile mixture of salt and water containing exactly 0.9% sodium chloride), pat dry, cover with calcium alginate (a natural, gel-like substance extracted from brown seaweed (kelp)) and cover with dry dressing (DD)/kerlix (a brand name for a puffy, crinkled type of medical gauze used to bandage and treat wounds). -No order for right foot heel protector. During a review of Resident 7's Braden Scale (BS) for Predicting Pressure Ulcer Risk Evaluation, dated 6/15/2026, the BS indicated the resident was high risk for pressure injury development and the BS did not indicate an intervention to apply a right foot heel protector. During a review of Resident 7's Care Plan (CP) Report titled, Wound: Skin integrity impairment and potential for (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infection manifested by wound (actual) on the right heel diabetic ulcer related to (r/t) aging process., last revised on 6/18/2026, the CP did not indicate application of right foot heel protector. During a concurrent observation and interview on 7/1/2026, at 10:37 a.m., with the Infection Preventionist (IP), inside Resident 7's room, observed Resident 7 had a right foot heel protector. The IP stated the resident had skin issues on the right foot and that was why the resident had a heel protector on. During a concurrent interview and record review on 7/1/2026, at 11:09 a.m., with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 7's Medical Diagnoses, OSR, BS, and CPs were reviewed. The MDS-RN stated she (MDS-RN) cannot find an order for the right foot heel protectors but found Santyl wound treatment for the right foot diabetic foot ulcer. The MDS-RN stated the resident was at high risk for developing pressure injury and there was a PRN wound consult order, and the CP also did not indicate to apply a right foot heel protector on the resident's right foot. The MDS-RN stated the licensed nurses should have obtained an order for the right heel diabetic foot ulcer to be applied with a right heel protector to ensure the intervention does not interfere with the physician's prescribed treatment as it involved diabetic and venous wound ulcer. The MDS-RN stated the circulation of blood in the right foot is already compromised and applying a heel protector can hinder blood flow that can affect the healing of the wound. The MDS-RN stated the failure of the licensed nurses to obtain an order and inform the physician of the added intervention had predisposed the resident to poor wound healing and complications brought about by diabetic and venous ulcers. During a concurrent interview and record review on 7/2/2026, at 11:01 a.m., with the Director of Nursing (DON), facility's recent policy and procedure (P&P) titled, Medication and Treatment Orders, was reviewed with the DON. The DON stated the staff should have obtained an order and informed the physician of the licensed nurses' application of right foot heel protectors to ensure the intervention added does not compromise the physician's treatment order. The DON stated the circulation is already impaired on resident 7's lower extremities, specifically the right foot, the application of a right heel protector could constrict the blood flow to the lower extremities that can cause poor blood circulation and slowed healing that can affect Resident 7 wound healing. The DON also stated the licensed staff did not follow the P&P titled, Medication and Treatment Orders. The DON also stated the CP titled, Wound: Skin integrity impairment and potential for infection manifested by wound (actual) on the right heel DM ulcer r/t aging process., last revised on 6/18/2026 was not updated with their application of the right foot heel protector. The DON stated the CP should have been updated to ensure all healthcare providers were aware of the interventions applied to the resident. During a review of the facility's recent P&P titled, Medication and Treatment Orders, last reviewed on 9/27/2025, the P&P indicated orders for medications and treatment will be consistent with principles of safe and effective order writing. Policy Interpretation and Implementation 1. Medications/Tx (per DON applicable for Treatments too) shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. ^		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received services and assistance for one of two sampled residents (Resident 5) reviewed for urinary catheter (a thin, flexible, hollow tube inserted into the bladder to drain urine (pee) when a person cannot urinate normally) or urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to ensure Resident 5's urinary catheter was secured on the leg strap (an adjustable fabric band used to secure a urinary catheter and its collection bag directly to the thigh or calf) or stat lock (a specialized, adhesive device used in hospitals to securely hold a catheter tube in place on a patient's skin). The deficient practices had the potential for residents to develop UTI. Findings: During a review of Resident 5's Face Sheet (FS - admission Record), the FS indicated the facility admitted the resident on 9/22/2025, and readmitted the resident on 6/24/2026, with diagnoses including UTI, sepsis (a life-threatening blood infection), and bacteremia (the presence of live bacteria in the bloodstream). During a review of Resident 5's History and Physical (H&P), dated 6/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 4/3/2026, the MDS indicated the resident sometimes had the ability to make self-understood and sometimes had the ability to understand others and had moderately impaired cognitive skills (a person has noticeable trouble with memory, focus, or decision-making, requiring some assistance to manage daily tasks like cooking, taking medications, or handling finances). The MDS indicated the resident had a catheter. During a review of Resident 5's Order Summary Report (OSR), dated 6/24/2026, the OSR indicated an order for: - [Catheter] Secure Foley Catheter (a brand of urinary catheter) tubing with anchor every day shift (To minimize dislodging of Catheter) with anchor every day shift (to minimize dislodging of catheter). - [Catheter] Foley catheter care every day shift. During a review of Resident 5's Care Plan (CP) Report regarding the resident having an alteration in urinary elimination and at risk for UTI secondary to use of Foley catheter due to obstructive uropathy (a blockage in the urinary system that prevents urine from flowing naturally), urinary retention (the inability to completely or partially empty the bladder), and benign prostatic hyperplasia (BPH, the non-cancerous enlargement of the prostate gland), last revised on 6/28/2026, the CP indicated an intervention for Foley catheter care (daily hygiene and routine maintenance to prevent urinary tract infections (UTIs) and ensure unobstructed urine flow) every (q) shift or as ordered. During a concurrent observation and interview on 6/29/2026 at 10:39 a.m. with Certified Nursing Assistant (CNA) 1, inside Resident 5's room, observed Resident 5 had a leg strap but the catheter tubing was not secured on it. CNA 1 stated the catheter tubing should always be secured with a leg strap to prevent accidental dislodgement of the urinary catheter tubing. During a concurrent interview and record review on 7/1/2026 at 11:47 p.m. with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 5's Medical Diagnoses, OSR, CP, and the facility's policies and procedures (P&P) were reviewed. The MDS-RN stated there was an order to secure Foley catheter with anchor every day shift. The MDS-RN stated the urinary catheter of Resident 5 was not secured to a leg strap and there was a potential for the urinary catheter tubing of the resident to get tugged and pulled that can result to meatal (the opening of the urethra) tear creating a portal of entry for infection leading to UTIs. The MDS-RN stated the P&Ps titled, Indwelling (Foley) Catheter Insertion, Male Resident, last reviewed on 9/27/2025, and Catheter Care, Urinary, last reviewed on 9/27/2025, were not followed by failing to ensure that the staff secured the catheter with a (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	securement device to prevent friction and movement of the catheter. During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the Director of Nursing (DON), the facility's P&P on urinary catheters and Resident 5's CP having an alteration in urinary elimination due to presence of a urinary catheter were reviewed. The DON stated the urinary catheter of Resident 5 should always be secured with a securement device such as a leg strap to prevent friction and irritation on the resident's meatal opening. The DON stated the failure of the staff to secure the urinary catheter with a securement device can lead to resident's urinary catheter getting pulled out causing pain and bleeding at the insertion site and infection due to reinsertion of the catheter tubing. The DON stated the irritation at the meatal opening of the resident can lead to accidental tear that can be an entry point for infection to set in. The DON stated the P&Ps titled, Indwelling (Foley) Catheter Insertion, Male Resident and Catheter Care, Urinary, were not followed by failing the staff failing to ensure the urinary catheter was secured with a securement device during routine catheter care. During a review of the facility's recent P&P titled, Indwelling (Foley) Catheter Insertion, Male Resident, last reviewed on 9/27/2025, the P&P indicated the purpose of this procedure is to provide guidelines for the aseptic insertion of an indwelling (Foley) urinary catheter in a male resident. Steps in the Procedure^ 13. Insert the catheter: f. Secure catheter tubing and/or bag to resident with approved catheter securement device. During a review of the facility's recent P&P titled, Catheter Care, Urinary, last reviewed on 9/27/2025, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. General Guidelines 4. Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure parenteral fluids (liquids, such as medication or nutrition, that are administered to the body by bypassing the digestive system) were administered consistent with professional standards of practice to one of three sampled residents (Resident 74) reviewed for hydration by failing to ensure Resident 74's peripheral intravenous (IV, within a vein) line (a small, flexible plastic tube [catheter] inserted through the skin into a small vein-usually in the hand, arm, or foot-to deliver fluids and medications directly into the bloodstream) had the time and initials of the licensed nurse who inserted the IV line or changed the IV dressing. This failure had the potential for complications associated with intravenous therapy (a medical technique that delivers fluids, medication, or nutrients directly into a person's bloodstream through a vein) and catheter-related infections. 2. Ensure a Curoc cap (a disinfecting cap for needless connectors) was placed on the y-injection site (a branching, y-shaped connector that allows healthcare professionals to inject medications via a syringe without interrupting the primary fluid flow) through the peripherally inserted central catheter (PICC - a long, flexible, and thin intravenous tube inserted into a vein in the upper arm and threaded toward the heart, used to deliver medications, antibiotics, or liquid nutrition) with total parenteral nutrition (TPN - a method of delivering all essential daily nutrients - including proteins, carbohydrates, fats, vitamins and minerals directly into the bloodstream via an IV catheter, bypassing the digestive system entirely) was infusing to one of two sampled resident (Resident 126). This failure had the potential for the resident to develop a Central Line-Associated Bloodstream Infection (CLABSI - a serious, potentially life-threatening infection that occurs when germs enter the bloodstream directly through a central line). Findings: 1. During a review of Resident 74's Face Sheet (FS - admission Record), the FS indicated the facility admitted the resident on 3/24/2007, and readmitted the resident on 4/1/2026, with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract), diaphragmatic hernia (occurs when there is an opening or weakness in the diaphragm (the muscle separating your chest and abdomen) without obstruction or gangrene (the death of body tissue caused by a loss of blood supply or a severe bacterial infection), and personal history of venous thrombosis (a blood clot that forms in a vein) and embolism (a sudden blockage in a blood vessel that stops blood from flowing). During a review of Resident 74's History and Physical (H&P), dated 4/4/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a resident assessment tool), dated 5/20/2026, the MDS indicated the resident sometimes had the ability to make self-understood and usually understand others and had moderate cognitive impairment (the middle stage of dementia, where cognitive and memory deficits become severe enough to disrupt daily independence). The MDS indicated the resident was on a high-risk drug class antibiotic (powerful, life-saving medicines that fight bacterial infections by killing bacteria or stopping them from growing and multiplying). During a review of Resident 74's Order Summary Report (OSR), dated 6/25/2026, the OSR indicated an order for: (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Peripheral site care as needed for complications. May extend IV site for poor venous access if no complications are present. Change dressing with site change and if needed (PRN). - Peripheral site care every 72 hours for Site care. Restart IV and subcutaneous (under the skin) site (Additional MD order required for insertion of IV catheter into lower extremities). During a concurrent observation and interview on 6/29/2026 at 9:13 a.m. with Registered Nurse (RN) 1, inside Resident 74's room, observed Resident 74 had a peripheral IV at the left forearm (LFA), dated 6/28/2026, with a green cap (a small, disposable plastic cap filled with 70% isopropyl alcohol) on the injection port without the time and the initials of the nurse who inserted or changed the dressing of the peripheral IV. RN 1 stated the peripheral IV should be dated, timed, and initialed by nurse who inserted or changed the dressing to know when the peripheral IV needed to be reinserted or changed with the dressing to prevent infection to set in. During a concurrent interview and record review on 7/1/2026 at 12:08 p.m. with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 74's Medical Diagnoses, OSR, and Policies and Procedures (P&P) were reviewed. The MDS-RN stated the peripheral IV care should have the date, time and initial whenever they insert or change dressing to know exactly the time and date and the person placed the IV or changed dressing by whom and they need to rotate the site too. The MDS-RN stated there is potential for infection to set in because they do not know how old the line is. Reviewed the facility's policy on peripheral IV insertion and care titled, Peripheral Venous Catheter Insertion, last reviewed 9/27/2025, and Peripheral Catheter Dressing Change, last reviewed 9/27/2025, with the MDS-RN, the MDS-RN stated the two policies were not followed by the licensed staff by failing to label the peripheral IV line with the time and the initials of the licensed nurse who inserted the line or changed the dressing. During a concurrent interview and record review on 7/2/2026 at 11:02 a.m. with the Director of Nursing (DON), the facility's recent policy on peripheral IV insertion and care was reviewed. The DON stated Resident 74's peripheral IV line dressing should have been dated, timed, and initialed by the nurse who inserted the line or changed the dressing to know how old the peripheral IV was and to know when to change the dressing to prevent infection on the insertion site. The DON stated the failure of the licensed staff to affix all the information on the resident's peripheral IV dressing had the potential for Resident 74 to develop phlebitis (the inflammation of a vein), thrombosis (a blood clot that forms inside a blood vessel (a vein or an artery) and blocks the flow of blood), and infection at the site. The DON stated the P&Ps titled, Peripheral Venous Catheter Insertion, last reviewed 9/27/2025, and Peripheral Catheter Dressing Change, last reviewed 9/27/2025, were not followed by the licensed staff by failing to label the peripheral IV line with the time and the initials of the licensed nurse who inserted the line or changed the dressing. During a review of the facility's recent P&P titled, Peripheral Venous Catheter Insertion, last reviewed on 9/27/2025, the P&P indicated on IV. Procedure: Q. Write date, time, and initials on the dressing label. During a review of the facility's recent P&P titled, Peripheral Catheter Dressing Change, last reviewed (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 9/27/2025, the P&P indicated under IV. Procedure: Q. Label dressing with date, time, and nurse's initials. 2. During a review of Resident 126's FS, dated 7/2/2026, the FS indicated that the resident was admitted on [DATE] with diagnoses including streptococcal sepsis (an extreme life-threatening body reaction to a strep bacterial infection), pneumonitis (lungs swollen and irritated), severe sepsis (a serious condition in which the body responds improperly to an infection), and chronic cough (a cough that lasts eight weeks or longer). During a review of Resident 126's H&P, dated 7/02/2026, the resident does not have the capacity to understand and make decisions. During a review of Resident 126's MDS, dated [DATE], the MDS indicated that the resident is dependent (helper does all of the effort, resident does none of the effort to complete the activity) on all of activities of daily living (ADLs &ndash; routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) including transfers. During a review of Resident 126's Care Plan (CP) titled, Potential for infection and/or complications related to central venous catheter (PICC LINE), initiated on 6/29/2026 had a goal indicating that central venous line catheter will be maintained and be free of infection/complications (.), with interventions including all IV equipment will be handled with aseptic technic, wash hands and use standard precautions, change all dressing every seven days and PRN wet, loose, or soiled using a transparent dressing. During a review of Resident 126's CP titled, Enhanced Barrier Precautions due to PICC line related to TPN use, initiated on 6/29/2029, the CP indicated a goal to reduce risk for active infection daily for three months, and interventions including cleaning and disinfection of equipment as needed and monitor signs and symptoms of infection. During a review of Resident 126's OSR, dated 6/29/2026, the OSR indicated an order for: Central Line and Midline Care every day shift, every 7 day(s) for site care. Change all central line, PICC and midline transparent dressing per sterile technique (upon admission if not dated or site not visible for assessment). Change injection cap to each lumen (the hollow, tubular space inside an IV catheter or needle through which fluids, blood, or medications flow). Change securement device. During an observation on 6/29/2026 at 10:47 a.m. inside Resident 126's room, observed Resident 126 had PICC line with two lumens with TPN infusing via tubing attached to one of the lumens that had y-insertion site, open to air and touching the bedsheet. During a concurrent observation and interview on 6/29/2026 at 1:52 p.m., inside Resident 126's room, with the Assistant Director of Nursing (ADON), the ADON stated Resident 126 has a PICC line with two ports, one had a tubing with y-injection site which had the TPN running. The ADON stated that the y-injection site does not have a Curoc cap and is open to air. The ADON stated that she was uncertain (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the y-injection site needed to be covered with a green Curoc cap and will have to look into the policy. During a concurrent interview and record review on 7/2/2026 at 9:02 a.m. with the ADON, the facility's P&P titled, PICC Needless Access Device Change, last reviewed 9/27/2025, was reviewed. The ADON stated that the y-injection site should have been closed with a green cap. The ADON stated that the P&P was not followed. During an interview on 7/2/2026 at 10:15 a.m. with the Infection Preventionist (IP), the IP nurse stated that all ports should be covered with green Curoc cap to prevent residents from developing CLABSI. During an interview on 7/2/2026 at 12:10 p.m. with the DON, the DON stated that all ports should be covered with a Curoc cap in order to maintain a closed system and prevent bloodstream infections which may result in sepsis. The DON stated the P&P was not followed. During a review of the facility's P&P titled, PICC Needless Access Device Change, reviewed on 9/27/2025, the P&P indicated A needless access device will be utilized at the hub of all venous access devices to decrease the risk of infection or injury. During a review of the facility's P&P titled, General Policies for IV Therapy, reviewed on 9/27/2025, the P&P indicated Disinfecting caps are intended for use on needless connectors only as a disinfecting cleaner prior to access and to act as a cover between line access. A new cap must be replaced on the needless connector after each use, do not reuse cap. During a review of the facility's P&P titled, Continuous Infusion of Medications and Solutions, reviewed on 9/27/2025, the P&P indicated Every attempt to maintain a closed system will be made.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for one of one sampled resident (Resident 74) reviewed for respiratory care area by failing to ensure the licensed staff used a humidifier (an attachment for oxygen tanks or oxygen concentrators that adds moisture to the pure oxygen) for Resident 74's 10 liters per minute (LPM, measures the volume of supplemental oxygen flowing into a patient's airways over 60 seconds) oxygen administration via face mask (a plastic device worn over the nose and mouth). The deficient practice had the potential for the resident to develop complications such as sore throat, nasal dryness, and coughing. The lack of moisture may also lead to nosebleeds or cracked, bleeding nasal passages. Findings: During a review of Resident 74's Face Sheet (FS), the FS indicated the facility admitted the resident on 3/24/2007, and readmitted the resident on 4/1/2026, with diagnoses including acute respiratory failure (a life-threatening medical emergency where the lungs suddenly stop working properly), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), and pneumonitis (the swelling and irritation (inflammation) of your lung tissue). During a review of Resident 74's History and Physical (H&P), dated 4/4/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS, a resident assessment tool), dated 5/20/2026, the MDS indicated the resident sometimes had the ability to make self-understood and usually understand others and had moderate cognitive impairment (a distinct middle-ground between normal age-related forgetfulness and full dementia). The MDS indicated the resident was on an oxygen therapy (a medical treatment that provides extra oxygen to people who cannot get enough on their own). During a review of Resident 74's Order Summary Report (OSR), dated 4/1/2026, the OSR indicated orders for: - [OXYGEN, O2] May have O2 inhalation without humidifier if O2 inhalation order is less than five (5) L/min as needed. - [OXYGEN] Change humidifier as needed when consumed. During a review of Resident 74's Care Plan (CP) Report titled, Oxygen. Resident is receiving Oxygen Therapy as ordered due to Acute on chronic congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), COPD exacerbation, acute respiratory failure with hypoxia (a condition where the body's tissues and organs do not receive enough oxygen to function properly), last revised on 4/2/2026, the CP indicated an intervention to provide oxygen as ordered and observe for safety when using oxygen. During a concurrent observation, interview, and record review on 6/29/2026, at 9:28 a.m., with Registered Nurse (RN) 1, inside Resident 74's room, observed Resident 74 on oxygen at 10 LPM via face mask without a humidifier on the oxygen set up. RN 1 stated Resident 74's oxygen vial face mask at 10 LPM should have a humidifier on. Reviewed Resident 74's OSR and RN 1 stated there was an order of may have O2 inhalation without Humidifier if O2 inhalation order is less than 5 L/min. RN 1 stated she (RN 1) should have attached a humidifier on the set up because the oxygen was running above 5 LPM to prevent the resident from having dry nasal passages that can cause coughing and irritation to the respiratory passages of the resident. During a concurrent interview and record review on 7/1/2026, at 12:12 p.m., with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 74's Medical Diagnoses, OSR, and CPs were reviewed. The MDS-RN stated there was an order of may have O2 inhalation without Humidifier if O2 inhalation order is less than 5 L/min per physician. The MDS-RN stated the nurse who started oxygen at 10 LPM via mask should have attached a humidifier on the oxygen set up to prevent Resident 74 respiratory passageways to dry up and cause discomforts such as nosebleeds and sore throat. The MDS-RN stated the licensed staff did (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not follow the physician's order and the CP titled, Oxygen. Resident is receiving oxygen therapy as ordered due to Acute on chronic CHF, COPD exacerbation, acute respiratory failure with hypoxia by failing to attach a humidifier on the oxygen set up to deliver a high-flow oxygen safely to the resident. During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the Director of Nursing (DON), facility's recent policy and procedure (P&P) regarding oxygen administration was reviewed. The DON stated the licensed staff should have attached a humidifier on Resident 74's oxygen setup which was running at 10 LPM of oxygen via face mask. The DON stated that the failure of the staff to attach a humidifier on the oxygen set up had the potential for the resident to have dry respiratory passages that can cause coughing, sore throat, and nose bleeds on Resident 74. The DON stated the licensed staff did not follow their P&P titled, Oxygen Administration by not attaching a humidifier on oxygen therapy with greater than 5 LPM of oxygen. During a review of the facility's recent P&P titled, Oxygen Administration, last reviewed on 9/27/2025, the P&P indicated the purpose of this procedure is to provide guidelines for safe oxygen administration. Equipment and Supplies The following equipment and supplies will be necessary when performing this procedure. 3.Humidifier bottle recommended for oxygen flow rates above 5L/min. ^		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the physician's order to apply half (1/2) side rails (a half-length bed rail is a safety barrier that covers only the top portion of a bed, typically near the user's torso) for two of two sampled residents (Residents 38 and 63) reviewed for bed rails (metal or plastic bars or guards attached to the sides of a bed to act as a barrier or support). These deficient practices placed the residents at risk for potential accident such as a body part being caught between the rails, falls if a resident attempts to climb over, around, between, or through the rails. Findings: 1. During a review of Resident 38's Face Sheet (FS), the FS indicated the facility admitted the resident on 2/21/2024, and readmitted the resident on 3/8/2024, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (mild to moderate muscle weakness on one entire side of the body), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left and right ankle, and history of falling. During a review of Resident 38's History and Physical (H&P), dated 10/8/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 38's Minimum Data Set (MDS, a resident assessment tool), dated 6/16/2026, the MDS indicated the resident had the ability to make self-understood and usually understands others and had intact cognition (a person's brain functions normally in processing information, without significant impairment to memory, reasoning, or judgment). The MDS indicated the resident had an impairment on one side of the resident's upper extremity and had impairment on both sides of her lower extremity. The MDS indicated the resident was dependent to needing setup assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 38's Order Summary Report (OSR), dated 5/26/2026, the OSR indicated an order for [Support & Safety Device] bilateral upper half siderails up with padding as nonrestraint to increase independence with self-positioning due to decreased strength related to status post (s/p) stroke (happens when blood flow to an area of the brain is suddenly cut off or a blood vessel bursts). (Informed consent [IC, (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered] obtained after explanation of risks and benefits and verified with MD) every shift. During a review of Resident 38's Fall Risk Evaluation (FRE), dated 6/30/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 38's Care Plan (CP) Report titled, [Support & Safety Device] bilateral upper half siderails up with padding as nonrestraint to increase independence with self-positioning due to decreased strength related to status post (s/p) stroke, last revised on 3/26/2026, the CP indicated an intervention to prevent from leaning forward due to (d/t) poor trunk control. For the prevention/management of safety/injury from potential falls. During an observation on 6/29/2026, at 9:49 a.m., inside Resident 38's room, observed Resident 38 had bilateral upper quarter (1/4) side rails up ([or quarter-length rail] is a short, 18-inch safety barrier typically attached near the head or foot of a hospital bed) and padded. During a concurrent observation and interview on 7/1/2026, at 10:40 a.m., with the Maintenance Director (MD), inside Resident 38's room, observed Resident 38 had bilateral upper 1/4 side rails up and padded. The MD stated the resident had bilateral 1/4 side rails up and the facility does not have 1/2 bedrail or full bedrail available at the facility. During a concurrent interview and record review on 7/1/2026, at 11:51 a.m., with the Minimum Data Set- Registered Nurse (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(MDS-RN), Resident 38's Medical Diagnoses, OSR, FRE, CP and Side Rail/Entrapment (when a person gets accidentally caught, stuck, or tangled in the gaps around or between their mattress, bed frame, or safety rails) Assessment were reviewed. The MDS-RN stated there was a physician's order to apply bilateral upper half siderails up with padding as nonrestraint to increase independence with self-positioning due to decreased strength related to status post (s/p) stroke. The MDS-RN stated the side rails applied to Resident 38 was bilateral 1/4 bed rails and they did not follow the physician's order. The MDS-RN stated the failure of the facility to apply the correct measurement of the side rail had the potential for fall because it might not be enough to support the resident when the resident moves on the bed. The MDS-RN also stated the assessment, the consent, and the care plan was done for a bilateral 1/2 side rail not for bilateral 1/4 side rail which makes them all inappropriate because the intervention applied was incorrect. During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the Director of Nursing (DON), reviewed the facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails. The DON stated the licensed staff should have followed the physician's order to apply bilateral 1/2 bed rails for Resident 38, and they should have notified the Administrator (ADM) or the DON of its unavailability in the facility. The DON stated the failure of the staff to follow the physicians order to apply bilateral 1/2 bed rails had the potential for Resident 38 for accidents such as falls, entrapment, or fractures (break in bone). The DON stated the staff did not follow the facility's P&P titled, Bed Safety and Bed Rails. 2. During a review of Resident 63's FS, the FS indicated the facility admitted the resident on 7/3/2018, and readmitted the resident on 8/11/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), age-related cataract (the gradual clouding of the eye's natural lens that happens as you get older), and functional quadriplegia (the complete inability to move all four limbs due to extreme weakness, frailty, or severe disability, rather than actual physical damage to the brain or spinal cord). During a review of Resident 63's H&P, undated, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 63's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and rarely to never had the ability to understand others and had severely impaired cognition (a serious, lasting loss of mental capacity that interferes with a person's ability to live independently, think clearly, learn new things, or make decisions). The MDS indicated the resident was dependent to needing substantial assistance on mobility and ADLs. During a review of Resident 63's OSR, dated 2/17/2026, the OSR indicated an order for [Support and Safety Device] Low bed with bilateral upper siderails up to decrease potential injury due to unpredictable movement/behavior related to dementia every shift. During a review of Resident 63's FRE, dated 4/20/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 63's CP Report titled, [Support and Safety Device] Low bed with bilateral upper siderails up to decrease potential injury due to unpredictable movement/behavior related to dementia, last revised on 2/17/2026, the CP indicated an intervention to prevent from leaning forward due to (d/t) poor trunk control. For the prevention/management of safety/ injury from potential falls. During an observation on 6/29/2026, at 9:52 a.m., inside Resident 63's room, observed Resident 63 had bilateral upper 1/4 side rails up. During a concurrent observation and interview on 7/1/2026, at 10:40 a.m., with the MD, inside Resident 63's room, observed Resident 63 had bilateral upper 1/4 side rails up. The MD stated the resident had bilateral 1/4 side rails up and the facility does not have 1/2 bedrail or full bedrail available at the facility. During a concurrent interview and record review on 7/1/2026, at 11:51 a.m., with the MDS-RN, Resident 63's Medical Diagnoses, OSR, FRE, CP and Side Rail/Entrapment Assessment/Care Plan, dated 4/20/2026 were reviewed. The MDS-RN stated there was a physician's order to apply [Support and Safety Device] Low bed with bilateral upper siderails (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up to decrease potential injury due to unpredictable movement/behavior related to dementia. The MDS-RN stated the side rails applied to Resident 63 was bilateral 1/4 bed rails and they did not follow the physician's order. The MDS-RN stated the failure of the facility to apply the correct measurement of the side rail had the potential for fall because it might not be enough to support the resident when the resident moves on the bed. The MDS-RN also stated the assessment, the consent, and the care plan was done for a bilateral 1/2 side rail not for bilateral 1/4 side rail which makes them all inappropriate because the intervention applied was incorrect. During a concurrent interview and record review on 7/2/2026, at 11:02 a.m., with the DON, reviewed the facility's P&P titled, Bed Safety and Bed Rails. The DON stated the licensed staff should have followed the physician's order to apply bilateral 1/2 bed rails for Resident 63, and they should have notified the ADM or the DON of its unavailability in the facility. The DON stated the failure of the staff to follow the physicians order to apply bilateral 1/2 bed rails had the potential for Resident 63 to accidents such as falls, entrapment, or fractures. The DON stated the staff did not follow the facility's P&P titled, Bed Safety and Bed Rails. During a review of the facility's recent P&P titled, Bed Safety and Bed Rails, last reviewed on 9/27/2025, the P&P indicated resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup. The use of bed rail is prohibited unless the criteria for use of bed rails have been met. ^		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to account for two (2) doses of controlled substances (CS- medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics, drugs or controlled medication) for Resident 10 and one (1) of five (5) inspected medication carts (Medication Cart 3/AM) reviewed during the Medication Storage and Labeling task. This deficient practice resulted in inaccurate reconciliation of the controlled medication and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of abuse of prescription drugs or their use for unintended purposes) of CSs and placed Resident 10 at risk for poor pain management and harm from accidental narcotic overdose (administration of more than the prescribed dose) potentially leading to physical harm, hospitalization, and death. Findings: During a review of Resident 10's admission Record (AR or Face Sheet), the AR indicated that the facility admitted the resident on 10/1/2020 and most recently re-admitted the resident on 2/20/2026 with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic pain syndrome (a condition where pain lasts longer than three months), osteoarthritis (OA, a progressive disorder of the joints, caused by a gradual loss of cartilage) of the left shoulder and right knee, and neuropathy (when nerve damage interferes with the functioning of the peripheral nervous system). During a review of Resident 10's History and Physical (H&P), dated 2/20/2026, the H&P indicated the resident had the capacity to make medical decisions. During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool), dated 6/5/2026, the MDS indicated the resident had the ability to make herself understood and had the ability to understand others. The MDS indicated the resident required substantial / maximal assistance from staff with bathing and lower body dressing; required partial / moderate assistance with toileting, personal hygiene, and upper body dressing; and received as needed (PRN) opioids (a CS used for pain management). During a review of Resident 10's Order Summary Report, the Order Summary Report indicated the following physician orders: -Hydrocodone-Acetaminophen tablet 5-325 milligrams (MG, a unit of measurement), give one tablet by mouth every eight hours PRN for severe pain, dated 2/20/2026. During a review of Resident 10's Care Plan (CP) titled, PAIN. I, (Resident 10), am at risk for pain and discomfort related to aging process, exercises and other medical diagnosis: Parkinson's Disease, OA, chronic pain syndrome, muscle spasms, neuropathy, . , initiated 10/12/2026, the CP indicated nursing staff would administer pain medication as ordered. During a review of Resident 10's CP titled, Hydrocodone/acetaminophen. At risk for adverse effects . hydrocodone/acetaminophen exposures (residents) and other users to the risks of opioid addiction, abuse, and misuse, which can lead to overdose and death, initiated 2/15/2026, the CP indicated a goal that the resident's risk for the use of hydrocodone/acetaminophen would be monitored/identified by the licensed nurse. During an interview on 6/29/2026 at 9:08 a.m., with Resident 10, Resident 10 stated she (Resident 10) was having less pain and was not getting a lot of pills. During a concurrent interview and record review on 6/30/2026 at 12:59 p.m. at Medication Cart 3/AM, with Licensed Vocational Nurse (LVN) 1, Resident 10's Controlled Drug Record (CDR- accountability record of medications that are considered to have a strong potential for abuse) for hydrocodone/acetaminophen and medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2026 were reviewed. LVN 1 stated there is a system for CS administration. LVN 1 stated the facility process for CS administration is to remove the medication (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the bubble pack (a package that contains multiple sealed compartments with medication), sign the CDR indicating the date and time of removal, administer the medication, and then document the administration in the MAR. LVN 1 reviewed Resident 10's CDR for hydrocodone/acetaminophen and MAR and noted the following: - On 5/4/2026 at 5:22 p.m., a dose of hydrocodone/acetaminophen was removed from the bubble pack and not documented as administered in the MAR. -On 5/5/2026 at 2 p.m., a dose of hydrocodone/acetaminophen was removed from the bubble pack and not documented as administered in the MAR. LVN 1 further stated LVN 2 removed the hydrocodone/acetaminophen on 5/5/2026. During a concurrent interview and record review on 6/30/2026 at 1:15 p.m., with LVN 2, Resident 10's CDR and MAR for 5/2026 and Progress Notes for 5/2026 were reviewed. LVN 2 stated CS's are highly addictive and the facility process is to document the removal of the medication from the bubble pack in the CDR and then document the administration of the medication in the MAR. LVN 2 stated he (LVN 2) did not remember what happened on 5/5/2026. LVN 2 stated he (LVN 2) removed the hydrocodone/acetaminophen for Resident 10 and did not document that it was administered in the MAR, but he (LVN 2) should have. LVN 2 stated when hydrocodone/acetaminophen was not documented as administered in the MAR it may appear that the medication was taken for abuse or to sell. During a concurrent interview and record review on 6/30/2026 at 1:25 p.m., with the Director of Nursing (DON), the DON reviewed Resident 10's CDR and MAR for 5/2026 and Progress Notes for 5/2026. The DON stated the MAR is proof that a narcotic was given and is referenced by the licensed nurses to know when pain medication may be given next. The DON stated when narcotic pain medication is given too close together it may result in over sedation or respiratory depression. The DON stated the facility process for administering PRN hydrocodone/acetaminophen is to document the administration in the MAR and then follow up and complete an assessment to make sure the medication was effective. The DON stated on 5/4/2026 at 5:22 p.m. and 5/5/2026 at 2 p.m. there was no documentation that hydrocodone/acetaminophen was administered or followed up on for Resident 10 potentially resulting in unmet pain management needs. The DON stated there was also a discrepancy created between the CDR and MAR potentially indicating diversion of a CS when the medication was removed and not given to the resident. During a follow-up interview and record review on 7/2/2026 at 10:08 a.m., with the DON, facility policy and procedure regarding CS was reviewed. The DON stated the facility P&P was not followed when two doses of hydrocodone/acetaminophen were not documented as administered to Resident 10 potentially resulting in diversion of CSs, overdose when narcotics are administered too close together, and/or poor pain management for Resident 10. During a review of the P&P titled, Controlled Medications, last reviewed 9/27/2025, the P&P indicated, The facility complies with all laws, regulations, and other requirements related to administration, handling, storage, disposal, and documentation of controlled medications. Policy Interpretation and Implementation. 1. Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises. 2. Personnel who are authorized to handle controlled substances are approved by the director of nursing services. Controlled substances are stored in the medication cart in a locked container, separate from containers for any non-controlled medications. 4. Access to controlled medications remains locked at all times and access is recorded. 6. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift. 8. Upon Administration: a. The nurse administering the medication is responsible for recording: (1) name of the resident receiving the medication; (2) name, strength and dose of the medication; (3) time of administration; (4) method of administration; (5) quantity of the medication remaining; and (6) signature of nurse administering medication.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure a resident's drug/medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for one of one sampled resident (Resident 5) reviewed for anticoagulant (blood thinner) use by failing to monitor Resident 5 for adverse effects (any unwanted, unpleasant, or harmful result caused by a medical treatment) such as sign and symptoms of bleeding for the use of Eliquis (a prescription blood thinner). This deficient practice could result in increased risk of a broad range of adverse consequences such as bleeding. Findings: During a review of Resident 5's Face Sheet (FS), the FS indicated the facility admitted the resident on 9/22/2025, and readmitted the resident on 6/24/2026, with diagnoses including atherosclerotic heart disease (the clogging of your arteries with sticky, fatty deposits called plaque), long term use of anticoagulants (medications that stop your blood from clotting too easily), and coronary angioplasty (is a procedure that opens clogged heart arteries using a tiny balloon) implant (any artificial device or tissue that a doctor places inside or on the surface of your body to replace a missing part, support a damaged structure, or improve how your body works) and graft (any artificial device or tissue that a doctor places inside or on the surface of your body to replace a missing part, support a damaged structure, or improve how your body works). During a review of Resident 5's History and Physical (H&P), dated 6/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/3/2026, the MDS indicated the resident sometimes had the ability to make self-understood, sometimes had the ability to understand others, and had moderately impaired vision. The MDS indicated the resident had moderately impaired cognitive skills (a person has noticeable trouble with thinking, memory, or learning) and was totally dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was on a high-risk drug class anticoagulant. During a review of Resident 5's Order Summary Report (OSR), dated 6/24/2026, the OSR indicated an order for Eliquis oral tablet five (5) milligrams (mg, a unit of weight) (apixaban). Give one tablet via gastrostomy tube (g-tube, a small medical tube inserted directly through the abdomen into the stomach) two times a day for deep vein thrombosis prophylaxis (DVT PPX, the preventive steps taken to stop blood clots from forming in the deep veins of the legs or thighs). During a review of Resident 5's Care Plan (CP) Report titled, Apixaban. At Risk for adverse effect from Black Box Med (a drug that carries the FDA's strictest safety warning) [Apixaban/Eliquis], last revised on 5/22/2026, the CP indicated an intervention to monitor for potential risk/effects and alert the physician when indicated. During a concurrent interview and record review on 7/1/2026, at 11:26 a.m., with the Minimum Data Set- Registered Nurse (MDS-RN) Resident 5's Medical Diagnoses, OSR, CP, and policy and procedure (P&P) were reviewed. The MDS-RN stated that there was an order for Eliquis and she (MDS-RN) was not able to find an order to monitor for adverse effects of its use for the resident. The MDS-RN added that there was a care plan but the intervention was not followed to monitor for potential risk/adverse effect. The MDS-RN stated the failure of the staff to monitor for the adverse effect on the use of Eliquis had predisposed the resident for bleeding, hematuria (blood in the urine), and hemoptysis (coughing or spitting up blood originating from the lungs or airways). The MDS-RN stated the P&P titled, Anticoagulation- Clinical Protocol, last reviewed on 9/27/2025, and manufacturer's specification was not followed by the staff by not assessing for any signs and symptoms related to adverse drug reactions and the Highlights of Prescribing Information (HPI) was not followed by not monitoring for bleeding which could be serious (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and rarely may lead to death. During a concurrent interview and record review on 7/2/2026, at 11:01 a.m., with the Director of Nursing (DON), facility's P&P titled, Anticoagulation- Clinical Protocol, and the facility provided HPI on the use of Eliquis were reviewed. The DON stated Resident 5's use of Eliquis should have a physician's order, monitoring for adverse effects on its use, and a care plan. The DON stated the physician should order the monitoring for adverse effects on its use, and it should be monitored and documented in the electronic healthcare record every shift. The DON stated the P&P titled, Anticoagulation- Clinical Protocol was not followed by the physician not ordering the monitoring and the licensed staff failing to communicate with the physician that there was no monitoring for its adverse effect. The DON also stated the facility-provided HPI was also not followed since the HPI is indicating that Eliquis can cause bleeding which can be serious and rarely may lead to death. During a review of the facility's recent P&P titled, Anticoagulation- Clinical Protocol, last reviewed on 9/27/2025, the P&P indicated under Assessment and Recognition: 1. As part of the initial assessment, the physician and staff will identify individual who are currently anticoagulated; for example, those with a recent history of deep vein thrombosis (DVT), or heart valve replacement, atrial fibrillation or those who have had recent joint replacement surgery. a. Assess for any signs and symptoms related to adverse drug reactions due to the medication alone or in combination with other medications. Monitoring and Follow-Up5. The staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. During a review of the facility provided HPI, on the use of Eliquis (apixaban) tablets for oral use, with initial U.S. Approval in 2012, the HPI indicated Eliquis can cause bleeding which can be serious and rarely may lead to death. This is because Eliquis is a blood thinner medicine that reduces blood clotting.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 26) was not charged for the loss of dentures when Resident 26 paid \$800 for the resident's lost dentures. This failure had potentially violated the right of the resident to have a replacement of lost dentures free of cost. Findings: During a review of Resident 26's admission Records, the admission Record indicated the facility initially admitted the resident on 7/26/2019 and readmitted the resident on 3/9/2024 with diagnoses including hemiplegia (paralysis of one entire side of the body) and hemiparesis (weakness or partial loss of movement on just one side of the body) following cerebral infarction (also known as a stroke, when blood flow is cut off in the brain) affecting left non-dominant side. During a review of Resident 26's History and Physical (H&P), dated 4/3/2026, the H&P indicated that the resident had the capacity to understand and make medical decisions. During a review of Resident 26's Minimum Data Set (MDS - a resident assessment tool), dated 5/6/2026, the MDS indicated that the resident had the ability to make self-understood and understand others. The MDS indicated the resident needed setup or clean-up assistance (helper sets up or cleans up; resident completes activity), and substantial/maximal assistance (helper does more than half the effort) when performing oral and personal hygiene, toileting and bathe self; and partial to moderate assistance with transfers. During a review of Resident 26's Concern Record (Theft/Loss and Grievance Report), dated 6/5/2026, the record indicated Resident 26 lost full upper dentures on 6/4/2026 and was unable to recall where he left them. During an interview on 6/30/2026 at 1:40 p.m. with Resident 26 during the Resident Council meeting, Resident 26 stated that he had filed a grievance for the loss of his upper denture. Resident 26 stated he got frustrated when he had to pay \$800 dollars for the replacement of his lost denture when it was not even his fault. Resident 26 stated sometime in May, he placed his dentures at the bedside table after having a meal when suddenly, he could not find his upper denture. During a concurrent interview and record review on 7/1/2026 at 11:55 a.m. with the Social Services (SS), Resident 26's Inventory List - Resident Clothing & Possessions, effective date 5/6/2026, was reviewed. The SS stated Resident 26 had gotten his upper denture last year and was listed in the Inventory List resident clothing and possessions. The SS stated that on 6/5/2026 it was reported to the facility that Resident 26 had lost his dentures and immediately did an investigation, but the upper denture was nowhere to be found. The SS stated that Resident 26 was provided assistance with arranging a dental referral for dental consult. The SS stated Resident 26 was informed that he had to pay \$800 for timely availability of the denture. The SS stated that Resident 26 would prefer to pay for the dentures and could not wait for the insurance processing. The SS stated that the family member was willing to cover the cost of the denture replacement. During a follow-up interview on 7/1/2026 at 1:50 p.m. with the SS, the SS stated that reason why Resident 26 had to pay for \$800 was because the resident had just gotten the dentures last year and since Medical had just paid last year for the dentures and that Medical only pays once every five years, the resident was not eligible for a new set of dentures. The SS stated that since Resident 26 lost his dentures in the facility, reimbursement should have been provided by the facility. The SS stated that she did not initiate a reimbursement because the family member was agreeable to covering the expense. During an interview on 7/2/2026 at 12:15 p.m. with the Director of Nursing (DON), the DON stated since the denture was misplaced in the facility, Resident 26 was not required to cover for the cost of lost denture. The DON stated that even if the family member offered to pay for the replacement, the facility should facilitate reimbursement to the resident. The DON stated that the SS did not process the reimbursement. During a review of the facility's Policy and Procedure (P&P) (continued on next page)		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled, Dental Services, reviewed on 9/27/2025, the P&P indicated routine and emergency dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. The P&P indicated social services representatives will assist residents with appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible. The P&P indicated direct care staff will assist residents with denture care, including removing, cleaning and storing dentures, dentures will be protected from loss or damage; to the extent practicable, while being stored. The P&P further indicated lost or damaged dentures will be replaced at the resident's expense unless an employee or contractor of the facility is responsible for accidentally or intentionally damaging the dentures.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Licensed Vocational Nurse (LVN) 3 did not place a fluticasone-salmeterol aerosol inhaler (medication that reduces swelling and inflammation in the lungs) container on a resident's bedside rolling table then back into Medication Cart 1 for one of five sampled residents (Resident 108) during the Medication Administration task. 2. One of two sampled residents (Resident 3) reviewed for urinary catheter (a thin, flexible, hollow tube inserted into the bladder to drain urine when a person cannot urinate normally) or urinary tract infection (UTI - a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to label Resident 103's urinal bottle with the resident's name and date the bottle was provided to the resident. These failures had the potential to result in cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and spread communicable diseases and infections among staff and residents. Findings: 1. During a review of Resident 108's admission Record (AR or Face Sheet), the AR indicated the facility admitted the resident on 5/13/2026 and most recently admitted the resident on 5/28/2026 with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), UTI, candidiasis (a fungal infection caused by yeast), and a history of methicillin-resistant staphylococcus aureus infection (a serious type of infection caused by bacteria that is resistant to many common antibiotics). During a review of Resident 108's Minimum Data Set (MDS - resident assessment tool), dated 6/3/2026, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for transfers, toileting, and bathing; and, required substantial / maximal assistance from staff for personal and oral hygiene, upper body dressing, and moving from lying to sitting position. During a review of Resident 108's Order Summary Report, the Order Summary Report indicated the following orders: - Fluticasone-salmeterol aerosol powder breath activated 100-50 micrograms (mcg, a unit of measurement), one inhalation inhaled orally two times a day for COPD, rinse mouth after use, dated 6/18/2026. During a Medication Administration observation on 6/30/2026 at 9:27 a.m. with LVN 3 at Medication Cart 1, LVN 3 prepared Resident 108's medications and then entered the resident's shared room carrying a labeled box containing Resident 108's fluticasone-salmeterol aerosol inhaler. LVN 3 then immediately placed the box on the resident's bedside rolling table without first cleaning the table. LVN 3 administered Resident 108's medications, placed the used inhaler in the box taken from the table, walked back to Medication Cart 1 and placed the box inside the medication cart drawer. During an interview directly after the medication administration observation, LVN 3 stated LVN 3 placed the inhaler box on Resident 108's bedside rolling table without disinfecting the table and then returned the box to the medication cart drawer and placed it next to other residents' medications. LVN 3 stated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she normally did not bring the inhaler box into the resident's room and place it on the table, but she did today. LVN 3 then stated she should not have placed the inhaler box on Resident 108's table then back into the medication cart because it could result in cross contamination from the resident's dirty table to the medication drawer resulting in the spread of infection among residents. During a concurrent interview and record review on 7/2/2026 at 10:08 a.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) regarding medication administration and infection control were reviewed. The DON stated labeled boxes containing resident inhalers should not be taken into the resident's room because the box goes directly in the medication cart next to other resident's medications. The DON stated the P&Ps were not followed when LVN 3 placed Resident 108's inhaler box on the rolling table and then back in the medication cart potentially resulting in bacteria infecting residents who receive medications from the medication cart. During a review of the facility P&P titled, Administering Medications, last reviewed 9/27/2025, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. Staff follow established facility infection control procedures (e.g. handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications. During a review of the facility P&P titled, Infection Control, last reviewed 9/27/2025, the P&P indicated, The facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including when and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. 2. During a review of Resident 103's FS, the FS indicated that the facility admitted the resident on 4/3/2026, with diagnoses including UTI, retention of urine, history of falling, and depression (a serious mood disorder that causes persistent sadness, loss of interest in activities). During a review of Resident 103's H&P, dated 7/2/2026, the H&P understand others and had the capacity to make medical decisions. During a review of Resident 103's MDS, dated [DATE], the MDS indicated that the resident had the capacity to make self-understood and understand others. The MDS indicated that the resident needed supervision or touching assistance with eating, partial/moderate assistance to oral and personal hygiene, and dependent with toileting and showers. During a review of Resident 103's Care Plan (CP) titled, Alteration in elimination patterns related to (r/t): bowel and bladder (frequently incontinent) initiated on 4/14/2026, the CP indicate interventions including to monitor for incontinent episodes, good incontinent care with each episode, and monitor for signs and symptoms of UTI. The CP titled, Potential for unavoidable recurrent UTI (.) had interventions including, notify MD if any signs and symptoms of UTI such as complaints of pain, burning, increased temperature, change in urine character, cloudy, odor, amount, clarity, etc., and monitor incontinent episode and frequency. During a concurrent observation and interview on 6/29/2026 at 9:33 a.m. with Certified Nursing Assistant (CNA) 8, inside Resident 103's room, CNA 8 stated that the urinal found by the resident's bed did not have any label on it. CNA 8 stated that when a urinal is supplied to residents, all nurses providing direct resident care must ensure the urinal is labeled with the resident's name and date. CNA 8 stated that the urinals are typically replaced by night shift each Sundays, or as needed. CNA 8 stated it is important to label urinals with the residents' name and date, particularly in rooms with multiple residents as they could possibly interchange urinals which can lead to cross contamination. During an interview on 7/02/2026 at 12:10 p.m. with the DON, the DON stated that urinals should be labeled with the resident's name and date to ensure proper identification. The DON stated that unlabeled may (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inadvertently be used by another resident which can lead to cross contamination and UTI. The DON stated that the policy regarding Cleaning and Disinfecting Non-Critical Resident-Care Items was not followed. During a review of the facility's P&Ps titled, Cleaning and Disinfecting Non-Critical Resident Care Items reviewed on 9/27/2025, the P&P indicated the purpose of the procedure is to provide guidelines for disinfection of non-critical resident care items. General Guidelines include: 1. Single resident use items for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge. 2. Reusable items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g., bedpans, urinals).		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic (ATB, a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) use protocols and a system to monitor antibiotic use for two of two sampled residents (Residents 5 and 4) reviewed for antibiotic use by failing to ensure: 1. Resident 5's Cefepime (a potent prescription-only antibiotic used by hospitals and clinics to treat severe bacterial infections) and Ampicillin (a widely used, prescription antibiotic designed to treat various infections caused by bacteria) had monitoring for its adverse effects (an unwanted, harmful, or unpleasant physical or mental reaction caused by a medical treatment, such as a medication or surgery). 2. Resident 4's Meropenem (a powerful, broad-spectrum antibiotic) had monitoring for its adverse effects. These failures had placed the residents at risk for adverse effects and multidrug resistant organisms (MDRO, are types of bacteria or germs that have developed the ability to withstand multiple, common antibiotics that used to kill them) resistance to antibiotics. Findings: 1. During a review of Resident 5's Face Sheet (FS), the FS indicated the facility admitted the resident on 9/22/2025, and readmitted the resident on 6/24/2026, with diagnoses including urinary tract infection (UTI, an infection in the bladder/urinary tract), sepsis (a life-threatening blood infection), and bacteremia (the presence of bacteria in the bloodstream). During a review of Resident 5's History and Physical (H&P), dated 6/25/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 4/3/2026, the MDS indicated the resident sometimes had the ability to make self-understood and sometimes had the ability to understand others, and had moderately impaired cognition (a noticeable decline in memory, focus, or reasoning that makes daily life challenging, often requiring some assistance with complex tasks like managing medications or finances). During a review of Resident 5's Order Summary Report (OSR), dated 6/25/2026, the OSR indicated an order for: - Ampicillin Sodium Intravenous Solution Reconstituted 2 grams (gm, a unit of weight) (Ampicillin Sodium) Use 100 milliliters per hour (ml/hr., the speed at which intravenous [IV, within a vein] fluids or medications are pumped into a patient's bloodstream) intravenously every 8 hours for sepsis for 10 Days flush with 10 cubic centimeters (cc, a standard unit used to measure volume-the amount of three-dimensional space an object takes up) of normal saline (NS, a simple, sterile mixture of salt and water) before and after administration 2 gm (Ampicillin Sodium). Use 100 ml/hr. intravenously every 8 hours for sepsis for 10 Days flush with 10 cc of normal saline before and after administration. - Cefepime HCl Intravenous Solution 2 G gm/100 ml (Cefepime HCl). Use 100 ml/hr. intravenously every 8 hours for sepsis for 7 Days flush with 10cc of normal saline before and after administration. During a review of Resident 5's Care Plan (CP) Report titled, Resident is on Ampicillin for the treatment of Sepsis and Resident is on Cefepime IV for the treatment of Sepsis, last revised on 6/27/2026, both CPs indicated an intervention to assess for signs and symptoms complications and notify MD/responsible party. During a concurrent interview and record review on 7/1/2026, at 11:25 a.m., with the Minimum Data Set- Registered Nurse (MDS-RN), Resident 5's Medical Diagnoses, OSR, CP, and NC- Licensed Nurses Notes were reviewed. The MDS-RN stated antibiotics are significant medications, and they should be monitoring for adverse effects every shift. The MDS-RN stated there was no physician's order for monitoring for adverse effects on the use of Ampicillin and Cefepime. The MDS-RN stated usually the physician will order the monitoring for antibiotic therapy and it will be reflected in the Medication Administration Record (MAR) and filled out (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every shift by licensed nurses. The MDS-RN also stated that they also document the monitoring for adverse effect on the use of antibiotics in their NC- Licensed Nurses Notes every shift. Reviewed NC-Licensed Nurses Notes with the MDS-RN and found one shift in 6/29/2026 with missing adverse side effect (ASE) monitoring. The MDS-RN stated it was important to monitor for ASE on the use of antibiotics on Resident 5 to ensure the resident was free from ASE and if ASE was present to report to the physician to mitigate the issue. NC- Licensed Nurses Notes were reviewed from 6/25/2026 to present with the MDS-RN. During a concurrent interview and record review on 7/1/2026 at 4:01 p.m. with the Infection Preventionist (IP), the facility's policy and procedure (P&P) titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, last reviewed on 9/27/2025, was reviewed. The IP stated the licensed nurses administering antibiotics should monitor for adverse effects on its use to mitigate the adverse effects of the antibiotic and for the clinician to act on it. The IP stated the staff should document them in the progress notes every shift. The IP stated he was not collecting the ASE on the use of antibiotic and his antibiotic surveillance tracking form does not include adverse effects and he needed to add them on his list to collect data and to follow their P&P titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes. During a concurrent interview and record review on 7/2/2026 at 11:02 a.m. with the Director of Nursing (DON), the facility's P&P on Antibiotic Stewardship was reviewed. The DON stated that antibiotics are considered as significant medications. The DON stated the nurses' responsibility when administering antibiotics should ensure there was a physicians' order and the order should be the right dose, indication and monitoring of side effects/adverse effects. The DON stated that the doctor has to order the monitoring for adverse effects for the entire duration of the antibiotic therapy. The DON stated the failure of the licensed staff to monitor for adverse effects on the use of Ampicillin and Cefepime on Resident 5 had the potential for the resident to suffer from the adverse effects of the medication and antibiotic resistance. The DON stated the licensed staff did not follow their P&Ps titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, and Antibiotic Stewardship by failing to monitor the adverse effects on Resident 5's use of antibiotics. The DON also stated the facility did not monitor the adverse effects on the facility-provided Highlights of Prescribing Information (HPI) on Cefepime and Ampicillin. 2. During a review of Resident 4's FS, the FS indicated the facility admitted the resident on 4/27/2024, and readmitted the resident on 5/11/2026, with diagnoses including sepsis, local infection of the skin and subcutaneous tissue (the deepest layer of the skin, primarily composed of adipose tissue (fat) and loose connective tissue), and cellulitis (a skin infection that causes swelling and redness) left lower limb. During a review of Resident 4's H&P, dated 5/14/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's brain is working normally and without impairment). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 4's OSR, dated 5/11/2026, the OSR indicated an order for Meropenem Intravenous Solution Reconstituted 1 gm (Meropenem). Use 1 gram intravenously every 8 hours for Sepsis Peripheral IV Flush order: Flush with 10 milliliters (ml, a unit of volume) NS before and after IV medications. Maintenance: Flush with 10 ml NS. During a review of Resident 4's Baseline Care Plan (BCP), dated 5/12/2026, the BCP indicated an antibiotic order for Meropenem 1 gm IV every 8 hours (Q8H) times (X) 2 days Daptomycin 300 mg IV every 24 hours (Q24H) X 5 days, the BCP indicated an intervention to monitor potential drug reactions daily. During a concurrent interview and record review on 7/1/2026, at 12:16 p.m., with the MDS-RN, Resident 4's Medical Diagnoses, OSR, BCP, and NC- Licensed Nurses Notes was reviewed. The MDS-RN stated (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antibiotics are significant medications, and they should be monitoring for adverse effects every shift. The MDS-RN stated there was no physician's order for monitoring for adverse effects on the use of Meropenem. The MDS-RN stated usually the physician will order the monitoring for ASE on antibiotic therapy and it will be reflected in the MAR and filled out every shift by licensed nurses. The MDS-RN also stated that they also document the monitoring for adverse effect on the use of antibiotics in their NC- Licensed Nurses Notes every shift. Reviewed NC-Licensed Nurses Notes with the MDS-RN and found one shift in 5/12/2026 with missing ASE monitoring. The MDS-RN stated it was important to monitor for ASE on the use of antibiotics on Resident 4 to ensure the resident was free from ASE and if ASE was present to report to the physician to mitigate the issue. NC- Licensed Nurses Notes were reviewed from 5/11/2026 to present with the MDS-RN. During a concurrent interview and record review on 7/1/2026 at 4:01 p.m. with the IP, the facility's P&P titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, last reviewed on 9/27/2025, was reviewed. The IP stated the licensed nurses administering antibiotics should monitor for adverse effects on its use to mitigate the adverse effects of the antibiotic and for the clinician to act on it. The IP stated the staff should document them in the progress notes every shift. The IP stated he was not collecting the ASE on the use of antibiotic and his antibiotic surveillance tracking form does not include adverse effects and he needed to add them on his list to collect data and to follow their P&P titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes. During a concurrent interview and record review on 7/2/2026 at 11:02 a.m. with the DON, the facility's P&P on Antibiotic Stewardship was reviewed. The DON stated that antibiotics are considered as significant medications. The DON stated the nursing responsibility of the nurse administering antibiotics should ensure there was a physicians' order and the order should be the right dose, indication and monitoring of side effects/adverse effects. The DON stated the doctor has to order the monitoring for adverse effects for the entire duration of antibiotic therapy. The DON stated the failure of the licensed staff to monitor for adverse effects on the use of Meropenem on Resident 4 had the potential for the resident to suffer from the adverse effects of the medication and antibiotic resistance. The DON stated the licensed staff did not follow their P&Ps titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, and Antibiotic Stewardship by failing to monitor the adverse effects on Resident 4's use of antibiotics. The DON also stated the facility did not monitor the adverse effects on the facility-provided HPI on Meropenem. During a review of the facility's recent P&P titled, Antibiotic Stewardship- Review and Surveillance of Antibiotic Use and Outcomes, last reviewed on 9/27/2025, the P&P 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 facility-wide antibiotic stewardship. Policy Interpretation and Implementation 4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include: 1. adverse events. During a review of the facility's recent P&P titled, Antibiotic Stewardship, last reviewed on 9/27/2025, the P&P indicated on Policy Interpretation and Implementation: The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. 3. Training and education will include emphasis on the relationship between antibiotic use and: a. gastrointestinal disorders; b. opportunistic infections (e.g., C. difficile, Candida Albicans, etc.); c. medication interactions; and d. the evolution of drug-resistant pathogens. During a review of the facility-provided HPI on the use of Cefepime for injection, for intravenous or intramuscular use, with initial U.S. approval in 1996, the HPI indicated: Adverse Reactions/Side Effects - At the highest dose (2 g every 8 hours), incidence of adverse reactions was > 1% for rash, (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diarrhea, nausea, vomiting, pruritus, fever, and headache. During a review of the facility-provided Information on Ampicillin for Injection, USP, for intramuscular or intravenous use, undated, the Information indicated the following adverse reactions have been reported as associated with the use of ampicillin: Gastrointestinal: Glossitis, stomatitis, black hairy tongue, nausea, vomiting, enterocolitis, pseudomembranous colitis, and diarrhea. Hypersensitivity Reactions: Skin rashes and urticaria have been reported frequently. A few cases of exfoliative dermatitis and erythema multiforme have been reported. Anaphylaxis is the most serious reaction experienced and has usually been associated with the parenteral dosage form.		