STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056333	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Conv Hosp	13333 Fenton Avenue Sylmar, CA 91342

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to develop and implement a person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of three sampled residents (Resident 1) to address Resident 1's use of cephalexin (medication used to treat infection) and ciprofloxacin (medication used to treat infection). This failure had the potential for Resident 1's delays in the delivery of necessary care and services.Findings:During a review of Resident1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/3/2025, with diagnoses that included unspecified (unconfirmed) thoracic vertebra wedge compression fracture (a bone in the mid-back gets squashed, usually in the front, causing it to collapse), essential hypertension (high blood pressure that develops slowly over time with no single, clear cause like another illness or medication) and generalized muscle weakness. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/5/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for toileting, showering, and dressing. During a review of Resident 1's Physicians Order, dated 12/11/2025, the Order Summary Report indicated cephalexin tablet 500 milligram (mg-metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for urinary tract infection (UTI-an infection in the bladder/urinary tract) for seven days until 12/17/2025. During a review of Resident 1's Care Plan, dated 12/11/2025, and revised on 12/26/2025, the Care Plan on history of UTI indicated an intervention:Administer medication as orderedMonitor for side effects (any reaction to a treatment or medicine that is not the main reason a person was taking it) and report to physician if noted. During a review of Resident 1's Physicians Order, dated 12/14/2025, the Order Summary Report indicated ciprofloxacin hydrochloride oral tablet 500 mg, give one tablet by mouth two times a day for UTI for seven days. During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 12/2025, the MAR indicated Resident 1 received the following medications:Cephalexin from 12/11/2025, at 5 p.m., to 12/14/2025, at 5 p.m.Ciprofloxacin from 12/15/2025, at 9 a.m., to 12/21/2025, at 5 p.m. During a concurrent interview and record review on 12/31/2025, at 11:34 a.m., with Licensed Vocational Nurse 2 (LVN 2), Resident 1's eInteract Change in Condition Evaluation (CIC), dated 12/11/2025, the CIC indicated Resident 1 complained of urinary discomfort on 12/10/2025, and the physician was notified on 12/10/2025 at 2 p.m. On 12/11/2025, RN 1 notified the Physician of the urinalysis (test to check the urine for its look, concentration, and chemicals for clues about the health, revealing signs of infections, and or kidney problems) result, and the (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physician ordered oral cephalexin 500 mg two times a day for UTI for seven days. During a concurrent interview, and record review on 1/6/2026, at 8:45 a.m., with the Infection Preventionist (IP), Resident 1's Care Plans were reviewed. The IP stated residents on antibiotic (medication used to treat infection) like cephalexin and ciprofloxacin are monitored for signs and symptoms of infection and for any adverse reaction (any unwanted, harmful, or negative response to a medical treatment, such as a medication) for the duration of the antibiotic. The IP stated residents are monitored every shift and nurses document the monitoring in the Progress Notes. The IP stated care plan for use of antibiotics should be developed on the day antibiotics start. The IP stated for any change in antibiotic medication, the nurses should revise the care plan. The IP stated there were no care plan developed for Resident 1's use of cephalexin and ciprofloxacin. The IP stated she (IP) wanted the nurses to revise the care plan with the name of the antibiotic. The IP stated care plan is individualized plan of care created for the residents to make them better. The IP stated care plans guide nurses, so they (nurses) do not miss any intervention. The IP stated without an updated or revised care plan, nurses might possibly miss interventions and can potentially delay care for Resident 1. During an interview on 1/6/2026, at 9:33 a.m., with the Registered Nurse 1 (RN 1), RN 1 stated the facility updates the care plan with general interventions. RN 1 stated there was no direct effect on Resident 1 if his (Resident 1) care plan for use of antibiotics was not revised. During an interview on 1/6/2026, at 10:42 a.m., with the Director of Nursing (DON), the DON stated nurses should update the care plan based on the monitoring of the antibiotic to provide proper care based on the problem. During a concurrent interview and record review on 1/6/2026, at 11:03 a.m., with the DON, facility's policy and procedure (P&P) titled, Comprehensive Person-Centered Care Plans, dated 3/2022, and last reviewed on 9/10/2025, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial (the connection between your inner mental/emotional world and the outer social world) and functional needs is developed and implemented for each resident. 7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including. e. reflects currently recognized standards of practice for problem areas and conditions.10. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. 11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The DON stated Resident 1's care plan should be person centered and should have been revised as information about the residents and the residents condition change.

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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 interview, and record review, the facility failed to ensure a resident received care consistent with professional standards of practice to prevent pressure ulcer (localized damage to the skin and/or underlying tissue usually over a bony prominence) for one of three sampled residents (Resident 1) by failing to timely notify the Wound Care Physician of Resident 1's pressure ulcers. This failure had the potential for the development and worsening of pressure ulcers.Findings: During a review of Resident1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/3/2025, with diagnoses that included unspecified (unconfirmed) thoracic vertebra wedge compression fracture (a bone in the mid-back gets squashed, usually in the front, causing it to collapse), essential hypertension (high blood pressure that develops slowly over time with no single, clear cause like another illness or medication) and pressure-induced deep tissue damage (DTI-injury to the muscles and fat under the skin, often from prolonged pressure, making the skin look dark red or purple, like a deep bruise, even if the skin surface seems unbroken, and it can quickly worsen into a severe wound) of left heel and of other sites. During a review of Resident 1's admission Data Tool, dated 12/3/2025, the admission Data Tool indicated Resident 1 had the following pressure ulcers:Right deltoid (muscle that forms the rounded part of the shoulder) ulcer measuring 3.5 centimeter (cm- one-hundredth of a meter) long and 3.5 cm wide.Right lateral (away from the middle) forearm ulcer measuring 3 cm long and 3 cm wide.Right lateral knee ulcer measuring 4 cm long and 4 cm wide.Right Upper hip ulcer measuring 7 cm long and 3 cm wide.Right lower hip ulcer measuring 5 cm long and 5 cm wide During a review of Resident 1's Order Summary Report, dated 12/4/2025, the Order Summary Report indicated the following orders:1. paint left fifth metatarsal (little toe) with betadine and cover with dry dressing daily for 30 days2. paint right deltoid ulcer with betadine and cover with dry dressing daily for 30 days3. paint right lateral forearm with betadine and cover with dry dressing daily for 30 days4. paint right lateral hip proximal (closer to the center) with betadine and cover with dry dressing daily for 30 days5. paint right lateral knee ulcer with betadine and cover with dry dressing daily for 30 days During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/5/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. The H&P indicated Resident 1 had pressure ulcer to right shoulder, right rib area, right upper and lower hip, right elbow and right lateral leg. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for toileting, showering, and dressing. The MDS indicated Resident 1 was at risk for pressure ulcer, had unhealed pressure ulcers, had four unstageable (a pressure ulcer that is so covered with dead tissue or debris that a doctor cannot see the bottom of the wound to determine how deep it actually is) pressure ulcers present during admission and had one DTI present during admission. During a review of Resident 1's Interdisciplinary (IDT- a coordinated group of experts from several different fields who work together) Wound Management Update, dated 12/8/2025, the IDT Wound Management Updated indicated wound consult. During a review of Resident 1's IDT Wound Management Update, dated 12/16/2025, the IDT Wound Management Updated indicated wound consult. During a review of Resident 1's Order Summary Report, dated 12/17/2025, the Order Summary Report indicated Santyl (a prescription-strength used to help deep or stubborn wounds heal by dissolving dead skin and tissue) ointment 250 unit per gram, apply to right lateral hip distal ulcer, cleanse with normal saline (salt water), pat dry and apply Santyl cover with xerofoam (a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	specialized, yellow medical bandage designed to keep a wound moist and protected without sticking to it) then foam dressing daily for 30 days. During a review of Resident 1's Wound Assessment Details dated 12/17/2025, the Wound Assessment Details indicated the following Initial Examinations by the Wound Care Physician (WCP):right lateral knee pressure ulcer measuring 2.8 cm long, and 1.9 cm wideright inferior hip pressure ulcer measuring 4.6 cm long, 4.5 cm wide, and 0.1 cm deep. Surgical debridement (surgical procedure to remove non-viable tissue) is done and had a measurement of 4.6 cm long, 4.5 cm wide, and 0.2 cm deep after debridement.Right superior hip pressure ulcer measuring 4.5 cm long and1.5 cm wide.Right arm pressure ulcer measuring 2.4 cm long and 1.8 cm wide.Right shoulder pressure ulcer measuring 2.9 cm long and 3 cm wide. During an interview on 1/6/2026, at 11:15 a.m., with the Director of Nursing (DON), the DON stated she (DON) had called and spoke to the WCP and the WCP informed her (DON) that nobody had informed him (WCP) of Resident 1's pressure ulcer on 12/11/2025, when he (WCP) last visited the facility. During an interview on 1/6/2026, at 11:20 a.m., with Treatment Nurse (TN), TN stated he (TN) was in charge of wound care consult orders. TN stated they (TN) notify the WCP of resident's wounds when they (WCP) visit the facility weekly and not on the day of resident's admission. TN stated WCP was not informed on 12/4/2025, and 12/11/2025 when the WCP was here in the facility. TN stated the WCP did not see Resident 1 for 12 days after admission. TN stated on 12/17/2025, when WCP initially visited Resident 1, WCP did a surgical debridement of Resident 1's right lower hip pressure ulcer. TN stated WCP helps the facility manage wounds. TN stated Resident 1's wound could get worse because WCP was not informed timely. During an interview on 1/6/2026, at 11:48 a.m., with the DON, the DON stated surgical debridement removes the dead skin cells to have a proper healing of the wound. The DON stated delay in debridement could affect wound healing. The DON stated delay in debridement can slow down Resident 1's wound healing. During a review of facility's policy and procedure (P&P) titled, Clinical Protocol Pressure Ulcers/Skin Breakdown, dated 4/2018, and last reviewed on 9/10/2025, the P&P indicated, Assessment and Recognition1. The nursing staff and practitioner (a licensed healthcare professional, essentially a doctor or physician, qualified to diagnose, treat, and prevent illness, injuries, and other conditions by providing medical care) will assess and document an individual's significant risk factors for developing pressure ulcers; for example, immobility, recent weight loss, and a history of pressure ulcer(s).3. The staff and practitioners will examine the skin of newly admitted residents for evidence of existing pressure ulcers or other skin conditions.4. The physician will assist the staff to identify the type, (for example, arterial [a painful, slow-healing sore on the lower leg or foot caused by poor blood flow due to narrowed or blocked arteries] or stasis ulcer [a chronic, open sore on the lower leg, usually near the ankle, caused by poor blood flow where blood pools and puts pressure on skin vessels]) and characteristics (presence of necrotic [dead] tissue, status of wound bed) of an ulcer.5. The physician will help identify and define any complications related to pressure ulcers.Cause Identification:1. The physician will help identify factors contributing or predisposing (a person has a higher chance to develop a specific disease) residents to skin breakdown; for example, medical comorbidities such as diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) .2. The physician will clarify the status of relevant medical issues; for example, whether there is a soft tissue infection or just wound colonization (germs are living and multiplying on the surface of a wound, but they are not currently causing an infection or making you sick), whether the wound has necrotic tissue, and the impact of comorbid conditions on healing an existing wound.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to follow physician's order for one of three sampled residents (Resident 1) when Licensed Vocational Nurse 1 (LVN 1) administered atenolol (medication used to treat high blood pressure) at 9 a.m. on 12/25/2025, and 12/28/2025 and losartan (medication used to treat high blood pressure) at 9 a.m., on 12/25/2025, 12/26/2025, 12/27/2025 and 12/28/2025, to Resident 1 who had a systolic blood pressure (sbp- pressure in the arteries when the heart beats) below of 110 millimeter of mercury (mmHg-unit for measuring pressure) despite physician's order to hold (suspend the medication) the atenolol and losartan for blood pressure below 110 mmHg. These failures had the potential to result in Resident 1's uncontrolled hypotension (low blood pressure). Findings: During a review of Resident1's admission Record, the admission Record indicated the facility admitted Resident 1 on 12/3/2025, with diagnoses that included unspecified (unconfirmed) thoracic vertebra wedge compression fracture (a bone in the mid-back gets squashed, usually in the front, causing it to collapse), essential hypertension (high blood pressure that develops slowly over time with no single, clear cause like another illness or medication) and generalized muscle weakness. During a review of Resident 1's Order Summary Report, dated 12/3/2025, the Order Summary Report indicated the following orders:Atenolol oral table 50 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth daily for hypertension (HTN-high blood pressure), hold if sbp is less than 110 mmHg or pulse rate less than 60 beats per minute (bpm).Losartan potassium oral tablet 100 mg, give one tablet by mouth daily for HTN, hold for sbp less than 110 mmHg. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/5/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for toileting, showering, and dressing. During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 12/2025, the MAR indicated LVN 1 administered the following medication to Resident 1 on the following dates and times.Atenolol on 12/25/2025 at 9 a.m. with bp of 109/70 mmHg.Losartan on 12/25/2025 at 9 a.m., with bp of 109/70 mmHg.Losartan on 12/26/2025 at 9 a.m., with bp of 108/72 mmHg.Losartan on 12/27/2025 at 9 a.m., with bp of 106/68 mmHg.Losartan on 12/28/2025 at 9 a.m., with bp of 109/70 mmHg.Atenolol on 12/28/2025 at 9 a.m. with bp of 109/72 mmHg. During a concurrent interview, and record review on 1/6/2026, at 9:12 a.m. with LVN 1, Resident 1's Order Summary Report, dated 12/3/2025, and MAR, dated 12/2025, were reviewed. LVN 1 stated check mark in MAR indicated that medication was administered. LVN 1 stated he (LVN 1) held the atenolol and losartan on the following dates and times, but he (LVN 1) cannot prove that he (LVN 1) held the atenolol and losartan. LVN 1 stated Resident 1 could experience lethargy (feeling sluggish, drowsy, and having a significant lack of energy) because of low blood pressure due to administration of blood pressure medication to Resident 1 when his (Resident 1) blood pressure was already low. During an interview on 1/6/2026, at 9:33 a.m., with Registered Nurse 1 (RN 1), RN 1 stated LVN 1 should follow the physician order and held the blood pressure medication (atenolol and losartan) because the physician order was to hold the medication if sbp was below 110 mmHg. RN 1 stated Resident 1 could experience low blood pressure and will be at risk for fall. During an interview on 1/6/2026, at 10:42 a.m., with the Director of Nursing (DON), the DON stated because LVN 1 administered losartan and atenolol, Resident 1 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could experience hypotension. The DON stated nurses should follow the physician order and read the blood pressure parameter before medication administration. During a concurrent interview and record review on 1/6/2026, at 11:03 a.m., with the DON, facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, and last reviewed on 9/10/2025, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required time frame.11. The following information is checked/verified for each resident prior to administering medications. a. Allergies (body's defense system mistakenly attacks something harmless, leading to uncomfortable or dangerous physical reactions to medications); and b. Vital signs (simple measurements of the body's most basic functions [temperature, pulse, breathing, blood pressure] that show how well essential organs are working), if necessary. The DON stated the facility's P&P was to follow physician order.

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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. Based on interview, and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration), surveillance of infections (the systematic, ongoing collection, analysis, and distribution of data on disease occurrence) and administering medications for one of three sampled residents (Resident 1) by:Failing to monitor Resident 1 for the side effects (any reaction to a treatment or medicine that is not the main reason a person was taking it) or adverse effects (undesired or harmful effects) of cephalexin (antibiotic medication used to treat infection) on the following dates and times:12/11/2025, from 3 p.m. to 11 p.m.12/12/2025, from 3 p.m. to 11 p.m. 2. Failing to monitor Resident 1 for the side effects or adverse effects of ciprofloxacin (antibiotic medication used to treat infection) on the following dates and times:12/15/2025, from 7 a.m. to 3 p.m. 12/16/2025, from 7 a.m. to 3 p.m.12/18/2025, from 3 p.m. to 11 p.m. These failures had the potential to increase antibiotic resistance (don't respond to a drug) from unnecessary or inappropriate antibiotic use and had the potential for Resident 1 to experience adverse reaction. Findings: During a review of Resident1‘s admission Record, the admission Record indicated the facility admitted Resident 1 on 12/3/2025, with diagnoses that included unspecified (unconfirmed) thoracic vertebra wedge compression fracture (a bone in the mid-back gets squashed, usually in the front, causing it to collapse), essential hypertension (high blood pressure that develops slowly over time with no single, clear cause like another illness or medication) and generalized muscle weakness. During a review of Resident 1's History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/5/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS-a resident assessment tool) dated 12/5/2025, the MDS indicated Resident 1's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 1 was dependent on staff for toileting, showering, and dressing. During a review of Resident 1's Physicians Order, dated 12/11/2025, the Order Summary Report indicated cephalexin tablet 500 milligram (mg-metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for urinary tract infection (UTI-an infection in the bladder/urinary tract) for seven days until 12/17/2025. During a review of Resident 1's Care Plan, dated 12/11/2025, and revised on 12/26/2025, the Care Plan on history of UTI indicated an intervention:1. Administer medication as ordered2. Monitor for side effects and report to physician if noted. During a review of Resident 1's Physicians Order, dated 12/14/2025, the Order Summary Report indicated ciprofloxacin hydrochloride oral tablet 500 mg, give one tablet by mouth two times a day for UTI for seven days.During a review of Resident 1's Medication Administration Record (MAR- flowsheet that indicates medications given to a resident), dated 12/2025, the MAR indicated Resident 1 received the following medications:1. Cephalexin from 12/11/2025, at 5 p.m., to 12/14/2025, at 5 p.m.2. Ciprofloxacin from 12/15/2025, at 9 a.m., to 12/21/2025, at 5 p.m. During a concurrent interview, and record review on 1/6/2026, at 8:45 a.m., with the Infection Preventionist (IP), Resident 1's Physician Order, dated 12/11/2025, and 12/14/2025, and Progress Notes from 12/11/2025, to 12/21/2025, were reviewed. The IP stated Resident 1 had the cephalexin on 12/11/2025, and was changed on 12/14/2025, to ciprofloxacin. The IP stated residents on antibiotic like cephalexin and ciprofloxacin are monitored for signs and symptoms of infection and for any adverse reaction for the duration of the antibiotic. The IP stated residents are monitored (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every shift (7 a.m. to 3 p.m., 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.) and nurses document the antibiotic monitoring in the Progress Notes. The IP stated there were no documented antibiotic monitoring for the adverse effect of cephalexin on 12/11/2025, and 12/12/2025 from 3 pm to 11 p.m. The IP stated there was no documented monitoring for the adverse effect of ciprofloxacin on 12/15/2025, and 12/16/2025, from 7 a.m. to 3 p.m., and on 12/18/2025, from 3 p.m. to 11 p.m. The IP stated if monitoring for antibiotics was not consistent, nurses might not identify an adverse reaction that can be harmful to Resident 1 and can cause delay in care. During an interview on 1/6/2026 at 9:33 a.m., with Registered Nurse 1 (RN 1), RN 1 stated nurses monitor antibiotic use every shift and document in residents medical record so nurses would know if there was a change of condition. During an interview on 1/6/2026 at 10:42 a.m., with the Director of Nursing (DON), the DON stated nurses should monitor Resident 1 for the antibiotic use and adverse effects every shift based on the duration of the antibiotic and nurses need to document in Resident 1's Progress Notes or Daily Skilled Notes. The DON stated she (DON) expects the nurses to monitor every shift. During a review of facility's policy and procedure (P&P), titled, Antibiotic Stewardship, dated 12/2016, and last reviewed on 9/10/2025, the P&P indicated, Antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The purpose of our antibiotic stewardship program is to monitor the use of antibiotics in our residents. Training and education will include emphasis on the relationship between antibiotic use and:a. gastrointestinal disorders (medical conditions affecting the digestive system causing symptoms like abdominal pain, bloating and nausea.)b. opportunistic infections (an infection caused by germs that typically do not harm healthy people but take advantage of a weakened immune system [body's defense against infections])c. medication interactions; and . During a review of facility's P&P, titled, Surveillance for Infections, dated 9/2017, and last reviewed on 9/10/2025, the P&P indicated, 5. Nursing staff will monitor residents for signs and symptoms that may suggest infection, according to current criteria and definitions of infections, and will document and report suspected infections to the charge nurse as soon as possible. 2. The surveillance should include a review of any or all of the following information to help identify possible indicators of infections: . h. Antibiotic review. During a review of facility's P&P, titled, Administering Medications, dated 4/2019, and last reviewed on 9/10/2025, the P&P indicated, 23. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: . e. any complaints or symptoms for which the drug was administered. f. any results achieved and when those results were observed.