

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for one of four sampled residents (Resident 1), who was identified to have a skin discoloration on 5/23/2026. This deficient practice had the potential to negatively affect the delivery of care and services to Resident 1. Findings: During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility admitted Resident 1 on 11/19/2025 with diagnoses that included cerebral infarction (stroke- loss of blood flow to a part of the brain), need for assistance with personal care, unspecified dementia (a progressive state of decline in mental abilities), age-related cognitive decline (the gradual loss of thinking skills). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/21/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience and the senses) was severely impaired. The MDS indicated Resident 1 needed substantial/maximal assistance from staff with eating, oral hygiene, and personal hygiene and is dependent on staff for toileting hygiene and showering/bathing. During a review of Resident 1's Skin Observation documentation dated 5/23/2026, the Skin Observation document indicated Resident 1 was noted with a bruise, signed by Certified Nursing Assistant 1 (CNA 1) and Licensed Vocational Nurse 1 (LVN 1). During a concurrent interview and record review on 6/11/2026 at 12:47 p.m., with Treatment Nurse 1 (TN 1), reviewed Resident 1's care plans. TN 1 stated that Resident 1 did not have a care plan specific to Resident 1's discoloration/bruising. TN 1 stated that staff responsible for the development of Resident 1's care plan for discoloration/bruising is the licensed nurse that identified the discoloration/bruising. During a concurrent interview and record review on 6/12/2026 at 11:36 a.m., with the Director of Nursing (DON), reviewed Resident 1's care plans. The DON stated that Resident 1 did not have a care plan specific to Resident 1's discoloration/bruise that was noted on 5/23/2026. The DON stated that Resident 1 should have a care plan developed specific to Resident 1's discoloration/bruising to ensure appropriate and specific interventions were implemented to address Resident 1's discoloration/bruising such as increased monitoring to ensure the discoloration/bruising does not worsen. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care plans, last reviewed on 3/9/2026, the P&P indicated it is the policy of this facility that the interdisciplinary team (IDT- coordinated group of medical and support professionals who collaborate to create and execute a unified care plan for a resident) shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and time frames to meet a residence medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.		

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: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the needed resident-centered (an approach that puts the individual's needs, preferences and well-being at the heart of their care plan) care and services for three of four sampled residents (Resident 1, 3, and 4) by failing to: 1. Implement the facility's significant change in condition policy by not having documented evidence that a change in resident's condition was completed when a skin discoloration was identified on 5/23/2026 for Resident 1. This deficient practice had the potential to place Resident 1 at risk of not receiving appropriate care due to inaccurate and incomplete resident medical care information. 2. Notify Resident 3's physician after the resident refused scheduled hydralazine (medication used for hypertension [high blood pressure- the force of the blood pushing on the blood vessel walls is too high]) administration on 6/2/2026, 6/3/2026, and 6/4/2026. This deficient practice had the potential to result in unclear or inconsistent direction in the resident's plan of care and may have placed Resident 3 at risk for not receiving appropriate assessment and intervention related to hydralazine refusals. 3. Notify Resident 4's physician after the resident refused scheduled blood sugar monitoring (measures the amount of sugar in your blood to help manage diabetes [a disorder characterized by difficulty in blood sugar control and poor wound healing]) administration on 5/12/2026, 5/13/2026, 5/14/2026, 5/16/2026, 5/17/2026, 5/18/2026, and 5/19/2026. This deficient practice had the potential to result in unclear or inconsistent direction in the resident's plan of care and may have placed Resident 4 at risk for not receiving appropriate assessment and intervention related to hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar). Findings: a. During a review of Resident 1's Face Sheet, the Face Sheet indicated the facility admitted Resident 1 on 11/19/2025 with diagnoses that included cerebral infarction (stroke- loss of blood flow to a part of the brain), need for assistance with personal care, unspecified dementia (a progressive state of decline in mental abilities), age-related cognitive decline (the gradual loss of thinking skills). During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool) dated 5/21/2026, the MDS indicated Resident 1's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience and the senses) was severely impaired. The MDS indicated Resident 1 needed substantial/maximal assistance from staff with eating, oral hygiene, and personal hygiene and is dependent on staff for toileting hygiene and showering/bathing. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order for aspirin (medication that helps stop blood cells from clumping together, also used as a blood thinner to help prevent heart attacks and strokes) oral tablet chewable 81 milligrams (mg- units of measurement), give one tablet, ordered 2/10/2026. During a review of Resident 1's Order Summary Report, the Order Summary Report indicated an order to monitor for signs and symptoms of bleeding and bruising from antiplatelet (a type of medicine that stops blood cells [called platelets] from sticking together and clumping inside your blood vessels) use, ordered dated 3/9/2026. During a review of Resident 1's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2026, the MAR indicated that Resident 1 was not noted with any bleeding and bruising from antiplatelet use. During a review of Resident 1's Skin Observation documentation dated 5/23/2026, the skin observation document indicated Resident 1 was noted with a bruise, signed by Certified Nursing Assistant 1 (CNA 1) and Licensed Vocational Nurse 1 (LVN 1). During an observation on 6/11/2026 at 9:15 a.m., in Resident 1's room, observed Resident 1 in bed with a purple, green, and yellowish discoloration on Resident 1's left temporal area. During a concurrent observation and interview on 6/11/2026 at 9:18 a.m., with Treatment Nurse 1 (TN 1) in Resident 1's room, observed Resident 1 in bed. TN 1 stated that Resident 1 has a skin discoloration to Resident 1's left temporal area. TN 1 stated that TN 1 did not observe the purple, green, and yellowish discoloration on Resident 1's left temporal area prior to (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	today (6/11/2026). During a concurrent interview and record review on 6/11/2026 at 9:23 a.m., with TN 1, reviewed Resident 1's Changes of Condition (COC- a significant alteration in an individual's physical, mental, or functional status compared to their established baseline) and Progress Notes. TN 1 stated that there is no documented evidence of Resident 1 having a purple, green, and yellowish discoloration on Resident 1's left temporal area. During an interview on 6/11/2026 at 2:30 p.m., with CNA 1, CNA 1 stated that CNA 1 primarily provides care to Resident 1 during the 7 a.m. to 3 p.m. shift. CNA 1 stated that around 5/22/2026, CNA 1 cannot remember the exact date, CNA 1 informed Resident 1's charge nurse of Resident 1 having a purple discoloration on Resident 1's left side of forehead. CNA 1 stated that she filled out the Skin Observation document and the charge nurse signed it. During a concurrent interview and record review on 6/11/2026 at 2:46 p.m. with the Director of Nursing (DON), the DON reviewed Resident 1's Skin Observation document dated 5/23/2026. The DON stated that Resident 1's Skin Observation document dated 5/23/2026 indicated Resident 1 was noted with bruises and was signed by CNA 1 and LVN 1. During a concurrent interview and record review on 6/12/2026 at 10:00 a.m., with LVN 1, reviewed Resident 1's Skin Observation document dated 5/23/2026 and Resident 1's COCs and nursing progress notes on 5/23/2026. LVN 1 stated that when CNAs observe a change in a resident's skin condition, CNAs document on a Skin Observation document, and the document is given to a licensed nurse so that a licensed nurse can assess the resident's skin. LVN 1 reviewed Resident 1's Skin Observation document, dated 5/23/2026. LVN 1 stated that LVN 1 signed Resident 1's Skin Observation document dated 5/23/2026. LVN 1 stated that by signing the Skin Observation document he (LVN 1) acknowledged that CNA 1 had reported the skin abnormality to him. LVN 1 stated that CNA 1 reported a new skin finding of bruising on 5/23/2026. LVN 1 reviewed Resident 1's COCs and nursing progress notes on 5/23/2026 and stated that he did not document a COC for Resident 1's bruising and did not find any documentation that LVN 1 notified a treatment nurse. LVN 1 stated that he should have documented a COC because bruising is a change to a resident's baseline skin condition and should have notified a treatment nurse. LVN 1 stated that it is important to document all COCs of residents to ensure that proper monitoring could be initiated. LVN 1 continued to state that LVN 1 does not know what happened and that something must have been lost in translation. During an interview on 6/12/2026 at 11:30 a.m., with the DON, the DON stated that when a resident has a COC, the staff responsible to document the COC is the licensed nurse who acknowledged the COC. The DON stated that in this case, LVN 1 is the responsible staff who should have followed the COC process of documenting the COC, notifying Resident 1's physician, and notifying Resident 1's responsible party. The DON continued to state that because Resident 1's COC is related to skin, a treatment nurse should also have been notified and a skin assessment should have been conducted by the treatment nurse. During a review of the facility's policy and procedure (P&P) titled, Significant Change in Condition, Response, last reviewed on 3/9/2026, the P&P indicated it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. If at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the licensed nurse or nurse supervisor should be made aware. The nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using Situation, Background, Assessment, Recommendation (SBAR- a form filled out by licensed nursing staff for the purpose of communicating information about a resident's condition or other issue to other members of the health care team, including a resident's doctor) or similar process to obtain new orders or interventions. The resident will then be placed on the 24 hour report and nursing will provide no less than three (3) days of observation, documentation, in response to any interventions. The nurse will communicate the change to other departments as appropriate and updated communications will be available during morning report. Each department notified will (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	perform their own evaluation and assessment to determine if the change requires further intervention and implement actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident electronic medical record (EMR). The interdisciplinary team shall collaborate with the attending physician, resident, and or resident representative to review risk indicators and the plan of care. During a review of the facility's P&P titled, Skin and Wound Monitoring and Management, last reviewed on 3/9/2026, the P&P indicated: Weekly Skin Check: Licensed nurse should document skin evaluations in accordance with this policy and document on the appropriate skin assessment/evaluation weekly/PRN form. Skin inspection on showering: On shower days, CNAs to observe resident skin Identify areas of skin breakdown, discoloration, tears or readiness; Communicate findings to licensed nurse: 2) in writing, via Skin Observation-Shower: Form: Licensed nurse to acknowledge findings, document pertinent information on residence clinical record, and respond/obtain and implement treatment order as appropriate. Weekly skin check conducted by licensed nurse. All resident will have a head-to-toe skin check performed at least weekly by a licensed nurse. The licensed nurse should document the findings. Any changes in the condition of the resident skin as identified daily, weekly, monthly, or otherwise, must be communicated to: the resident/responsible party; the residence physician; others as necessary to facilitate healing. b. During a review of Resident 3's Face Sheet, the Face Sheet indicated the facility admitted Resident 3 on 7/23/2025 and readmitted the resident on 3/1/2026 with diagnoses that included hypertension. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 required setup or clean up assistance from staff for eating, oral hygiene, required supervision or touching assistance from staff for personal hygiene, and required partial/moderate assistance from staff for toileting hygiene and showering/bathing self. During a review of Resident 3's Order Summary Report dated, the Order Summary Report indicated an order for hydralazine oral tablet 25 milligrams (mg- unit of measurement), give three (3) tablets by mouth three times a day for hypertension, hold for systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) less than 120 millimeters of mercury (mm Hg- unit of measurement), ordered 3/2/2026. During a review of Resident 3's MAR for 6/2026, the MAR indicated that Resident 3 refused her scheduled hydralazine at 1:00 p.m. on the following days: 6/2/2026, 6/3/2026, and 6/4/2026. During a concurrent interview and record review on 6/12/2026 at 1:17 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 3's MAR for 6/2026. RN 1 stated that if a resident refuses medication for three consecutive days licensed nurses are to document a change in condition and notify the resident's physician. RN 1 stated that Resident 3 refused her 1:00 p.m. hydralazine doses on the following days: 6/2/2026, 6/3/2026, and 6/4/2026. RN 1 reviewed Resident 3's Progress Notes for 6/2026 and stated that there was no documented evidence that Resident 3's physician was made aware of Resident 3's consecutive hydralazine refusals on 6/2/2026, 6/3/2026, and 6/4/2026. During an interview on 5/12/2026 at 2:15 p.m., with the DON, the DON stated that when a resident refuses his/her medication for one day or one dose, the charge nurse assigned is responsible for notifying the residents' physician and initiating a COC document. The DON stated that Resident 3's physician should have been made aware of the missed doses because the medication missed is a medication for hypertension and Resident 3 should have been monitored more closely. The DON continued to state that if Resident 3 continued to refuse her hydralazine, charge nurses could ask to discontinue the medication. The DON stated that failure to notify Resident 3's physician may have resulted in delayed care and inadequate monitoring for hypertension that could lead to dizziness and avoidable falls. c. During a review of Resident 4's Face Sheet, the Face Sheet indicated the facility admitted Resident 4 on 6/26/2025 with diagnoses that included type 2 diabetes. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4's cognition was intact. The MDS indicated Resident 4 required setup or clean-up assistance from staff with eating, oral hygiene, and personal hygiene and required supervision or touching assistance from staff with toileting (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene and showering/bathing self. During a review of Resident 4's Order Summary Report, the Order Summary Report indicated an order for insulin aspart human injection solution (a rapid-acting insulin), inject per sliding scale (progressive increase in the insulin dosage, based on pre-defined blood glucose ranges), ordered 1/29/2026. During a review of Resident 4's MAR for 6/2026, the MAR indicated that Resident 4 refused his scheduled blood sugar check at 6:30 a.m. on the following days: 6/1/2026, 6/2/2026, 6/3/2026, 6/4/2026, 6/5/2026, 6/6/2026, 6/7/2026, 6/8/2026, 6/9/2026, 6/10/2026, 6/11/2026, and 6/12/2026. During a concurrent interview and record review on 6/12/2026 at 1:27 p.m., with RN 1 (RN 1), reviewed Resident 4's physicians orders and MAR for 6/2026. RN 1 stated that licensed nurses are to check Resident 4's blood sugar at 6:30 a.m. and administer insulin based on the sliding scale. RN 1 reviewed Resident 4's MAR for 6/2026 and stated that Resident 4 refused his 6:30 a.m. blood sugar checks on the following days: 6/1/2026, 6/2/2026, 6/3/2026, 6/4/2026, 6/5/2026, 6/6/2026, 6/7/2026, 6/8/2026, 6/9/2026, 6/10/2026, 6/11/2026, and 6/12/2026. RN 1 reviewed Resident 4's Progress Notes for 6/2026 and stated that there was no documented evidence that Resident 4's physician was made aware of Resident 4's repeated blood sugar check refusals on 6/1/2026, 6/2/2026, 6/3/2026, 6/4/2026, 6/5/2026, 6/6/2026, 6/7/2026, 6/8/2026, 6/9/2026, 6/10/2026, 6/11/2026, and 6/12/2026. During an interview on 6/12/2026 at 2:20 p.m., with the DON, the DON stated that the charge nurse assigned to Resident 4 should have called and informed Resident 4's physician of his refusal of blood sugar checks at 6:30 a.m. The DON stated blood sugar monitoring is important for a diabetic resident because nursing staff need to monitor residents blood sugar. The DON stated that the charge nurse should have suggested to the physician if it would be ok to change the time that Resident 4 gets his blood sugar checked or consider discontinuing Resident 4's blood sugar check. The DON stated that a COC should have been documented so that staff will be able to closely monitor Resident 4. The DON stated that failure to notify the physician may have resulted in delayed care, improper monitoring of hyperglycemia (high blood sugar) or hypoglycemia (low blood sugar), and delayed wound healing. During a review of the facility's policy and procedure (P&P) titled, Care and Treatment, Refusal, last reviewed on 3/9/2026, the P&P indicated it is the policy of this facility that each resident has a right to consent to or refuse any care, treatment or procedure to the extent permitted by law. When a resident refuses care or treatment, the interdisciplinary team will notify the resident or appropriate surrogate about the benefits of the treatment, possible clinical consequences of refusal of treatment, an alternate treatment currently available. This notification will be documented in the progress notes. The facility will notify the residents attending physician of refusals of care, treatments or procedures, and will document physician notification in the progress notes. Patterns of refusal for three (3) days or instances of refusal that directly threaten the health, safety and the well-being of the resident require physician and resident/surrogate notification. During a review of the facility's P&P titled, Documentation and Charting, last reviewed on 3/9/2026, the P&P indicated it is the policy of this facility to provide: 1. A complete account of the residents care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the residents care in an accurate and chronological manner; 4. Nursing service personnel with a record of the physical and mental status of the residents; 6. The elements of quality medical nursing care.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/12/2026
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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 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 interview and record review, the facility failed to ensure one of four sampled residents (Resident 4) received care and services in accordance with professional standards of practice by failing to administer Resident 1's Entresto oral tablet (medication used to reduce the strain on a weakened heart by relaxing blood vessels and helping the body remove excess fluid) as prescribed by the physician. This deficient practice resulted in the administration of Entresto oral tablet which could have resulted in adverse reactions (undesired harmful effect resulting from a medication or other intervention) such as hypotension (low blood pressure) and dizziness. Findings: During a review of Resident 4's Face Sheet, the Face Sheet indicated the facility admitted Resident 4 on 6/26/2025 with diagnoses that included essential hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]), ischemic cardiomyopathy (an issue with damaged heart muscle that can't pump blood well), presence of aortocoronary bypass graft (a surgical procedure used to treat blocked heart arteries [thick, muscular blood vessels that carry oxygen- and nutrient-rich blood away from the heart to the rest of the body]). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 4's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. The MDS indicated Resident 4 required setup or clean-up assistance from staff with eating, oral hygiene, and personal hygiene and required supervision or touching assistance from staff with toileting hygiene and showering/bathing self. During a review of Resident 4's Order Summary Report dated 6/26/2025, the Order Summary Report indicated an order for Entresto oral tablet 97-103 milligram (mg- unit of measurement), give one (1) tablet by mouth two times a day for hypertension, hold for systolic blood pressure (SBP - the first number in a blood pressure reading, which measures the pressure in the arteries [pathway that carries blood away from the heart] when the heart beats) less than 110 millimeters of mercury (mm Hg- unit of measurement). During a review of Resident 4's Medication Administration Record (MAR, a report detailing the medications administered to a resident by the licensed nurse in the facility) dated 6/2026, the MAR indicated that Resident 4 was administered Entresto oral tablet 97-103 mg on 6/2/2026 for a blood pressure of 101/59 mm Hg. During a concurrent interview and record review on 6/12/2026 at 1:41 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 4's MAR dated 6/2026. RN 1 stated that Resident 4 had a blood pressure reading of 101/59 mm Hg and was administered Entresto oral tablet 97-103 mg on 6/2/2026 at 9:00 a.m. RN 1 stated that Resident 4's Entresto oral tablet 97-103 mg should not have been administered. RN 1 continued to state that Entresto oral tablet 97-103 mg should have been held because of the physician ordered parameters (fixed limits). RN 1 stated that potential negative outcomes that could have occurred by administering Entresto oral tablet 97-103 mg and not following physician ordered parameters could be hypotension, dizziness, and avoidable falls. During a review of the facility's policy and procedure (P&P) titled, Medication Administration- Oral, last reviewed on 3/9/2026, the P&P indicated it is the policy of this facility to accurately prepare, administer and document oral medications.		