

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056363	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Grand Valley Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13524 Sherman Way Van Nuys, CA 91405	
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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to: 1. Ensure one of seven (7) sampled residents (Resident 56), who had an order for modified liquid consistency (liquids that have been thickened [drinks such as water, juice, coffee, modified with powders or gels to be easier and safer to swallow] to a specific level to improve swallowing safety per the International Dysphagia Diet Standardization Initiative [IDDSI - framework that provides a common terminology to describe food textures and drink thickness]), was not provided thin (water-like) liquids. The facility failed to: a. Ensure that Resident 56, who has a diagnosis of dysphagia (swallowing difficulties) and was at risk for aspiration (when food, liquid or other material enter a resident's airway and eventually the lungs), and who was placed on a restorative dining program (a nursing intervention designed to help residents maintain or regain their highest level of independence and safety during mealtime) requiring supervision and/or assistance during meals, was not served unthickened coffee with a straw during lunch, at approximately 12 p.m. on 12/29/2025. Resident 56 was observed coughing while drinking the unthickened coffee through a straw. b. Implement Resident 56's physician's diet order dated 10/10/2025, to provide Resident 56 liquids with nectar/mildly thick liquid consistency (refers to liquids that are thicker than water but still pourable, liquid will flow/pour from a spoon, quickly, but is slower than thin drinks). c. Ensure Licensed Vocational Nurse 1 (LVN 1), who was monitoring residents in the activity/dining room, verified that Resident 56's coffee was of the correct liquid consistency, in accordance with the facility's policy and procedure (P&P) titled, Thickened Liquids, last reviewed on 8/23/2025, which indicated that thickened liquids are to be served at the appropriate consistency as ordered by the physician and that hot beverages are to be mixed on the tray line (an assembly line used in healthcare settings to prepare and distribute meals to residents) or by nursing staff. d. Ensure Restorative Nursing Assistant 1 (RNA 1) and Restorative Nursing Assistant 2 (RNA 2), who were assisting residents in the activity/dining room, verify Resident 56's diet order with LVN 1 to ensure Resident 56's coffee was provided at the correct liquid consistency, in accordance with the facility P&P titled, Restorative Dining Program, last reviewed on 8/23/2025, which indicated the RNA dining program to be performed as ordered and care planned to allow residents to safely and effectively consume food and fluids. e. Implement Resident 56's Nutrition care plan related to dietary concerns/problems dated 10/14/2025, which identified Resident 56 as being at risk for aspiration, dehydration (a condition that occurs when the body does not have enough fluids to function properly), malnutrition (a condition that happens when the body does not get enough nutrients) and included interventions to provide Resident 56 with the diet as ordered. f. Implement Resident 56's Dysphagia care plan related to oropharyngeal dysphagia (a resident has trouble starting the swallow in the mouth or throat, leading to issues like coughing, choking [a life-threatening event where food, liquid or another object becomes lodged in a resident's airway obstructing their ability to breathe], food getting stuck or aspiration) dated 10/16/2025, which identified Resident 56 as at risk for aspiration and required aspiration precautions (a set of care strategies to prevent food or liquids from entering the airway [lungs]), including not using straws when consuming fluids. On 12/29/2025 during lunch, at approximately 12 p.m., Resident 56 was provided with unthickened coffee with a straw. These (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
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These failures had the potential to result in difficulty in swallowing, chewing, decrease in food intake and nutrient intake to 19 of 82 residents on puree diet, resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). On 12/30/2025 at 2:52 p.m., while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ- a situation in which the facility's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death of a resident) in the presence of the Administrator (ADM) and the Director of Nursing (DON), due to the facility's failure to provide food and drink prepared in a form designed to meet individual needs in accordance with S483.60(d)(3) by failing to provide Resident 56 coffee with nectar/mildly thick liquid consistency as ordered by the physician. On 1/1/2026 at 12 p.m., the ADM provided an IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) which included the following summarized actions: 1. On 12/29/2025, LVN 1 completed a Situation, Background, Assessment, Recommendation (SBAR - a structured communication tool used primarily in healthcare to provide concise, clear, and essential information about a resident's condition) regarding Resident 56's consumption of thin fluids. 2. On 12/29/2025, the DON assessed Resident 56 for any adverse (harmful or undesired) reactions or side effects related to Resident 56's consumption of thin liquids through a straw, no adverse findings were noted. 3. On 12/29/2025 the facility notified Resident 56's attending physician's nurse practitioner (NP) and Resident 56's family of the incident involving the provision (action of providing) of thin coffee with a straw. The NP ordered a stat (immediate) chest X-radiation (x-ray - a type of medical imaging that uses radiation to take pictures of the inside of the body). 4. On 12/29/2025, the Speech Therapist (ST - a person qualified to treat people with conditions that affect the production of speech, communication and swallowing problems) evaluated Resident 56 to assess oral (mouth) and pharyngeal (throat) swallowing function. The evaluation identified mild to moderate weakness of orofacial myofunctional (refers to disorders of the muscles in the face and mouth including the tongue, lips, and jaws), with a mild delay in swallow initiation, oral phase impairments characterized by delayed and incomplete bolus (a small, rounded mass of a substance) formation. The ST recommended continuation of a mildly thick liquid and pureed diet. 5. On 12/29/2025, the DON, Social Service Director (SSD) and Case Management scheduled an Interdisciplinary Team (IDT- a collaborative group of healthcare professionals working together with the resident and family member to create a unified, holistic care plan to address all of resident's needs) meeting with Resident 56's family member to discuss preferences related to the use of straws when consuming liquids and the prescribed fluid consistency. The risks and benefits of these preferences were to be discussed during the meeting. 6. On 12/29/2025, the Director of Staff Development (DSD) provided one-on-one (1:1) in-service (- refers to individualized, one-on-one education provided to a single individual by a staff member or professional) training to RNA 1 and RNA 2: a. Certified Nursing Assistant(s) (CNAs) are to verify the diet order on the diet list, which will be maintained in Nursing Station 1, the Dining Room, and the Activity Room. b. Liquids served to residents with modified liquid consistencies will be visually checked by a licensed nurse prior to serving. c. CNAs must verify with licensed nurses the use of straws before serving liquids to residents. 7. On 12/30/2025, the DON and designee conducted a review of residents on thickened liquids. The DON and designee verified that the liquids served at the bed side (place next to a resident's bed) matched the physician's orders. No other residents were (continued on next page)		

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Licensed nurses are responsible for verifying that liquids supplied to residents match the physician's order, especially for residents requiring modified liquid consistencies, before serving to residents. b. All beverages requiring modified textures will be prepared in the kitchen. 10. On 12/30/2025, DON provided a one-on-one in-service training to LVN 1, emphasizing verification of fluid consistency with the diet list before serving liquids. LVN 1 was instructed to verify the diet order on the diet list maintained in Nursing Station 1, Dining Room, and the Activity Room. 11. On 12/30/2025, the DON provided a one-on-one in-service training to the CNAs on the importance of verifying liquid consistency and straw use with licensed nurses prior to serving drinks/liquids to residents. The training included the following: a. CNAs to verify the residents' diet order using the diet list maintained in Nursing Station 1, the Dining Room, and the Activity Room. b. Liquids served to residents requiring modified liquid consistencies will be visually verified by a licensed nurse prior to serving. c. CNAs to verify with licensed nurses whether the use of straws is permitted before serving drinks/liquids to residents. Thickening agents (powders or gels added to liquids such as water, juice, and milk to increase their viscosity [thickness], making them easier and safer to swallow) are controlled dietary items and are not to be provided to or used by nursing staff. From 12/30/2025 until delivery, dietary services are responsible for preparing and labeling moderately thickened liquids. Education on the different types of thickened liquids and their proper preparation was provided. 12. On 12/30/2025, the RD provided in-service training to dietary staff based on the IDDSI guidelines to ensure resident safety, reduce aspiration risk, and maintain compliance with physician diet orders and swallowing precautions. Dietary staff on leave will receive in-service training upon return, provided by the Dietary Supervisor. 13. On the evening (time not specified) of 12/30/2025, licensed staff and CNAs received in-service training from the DON and the RD on the importance of providing residents with liquids of the appropriate consistency as ordered by the physician. a. The 7-3 RN Supervisor or designee will print the diet list daily. The LVN or the RN Supervisor is responsible for updating the diet list with any new diet orders or admissions. The diet list will be available in the Nursing Station 1, the Dining Room, and the Activity Room. A copy of the diet list will be provided to the dietary department daily. b. Licensed nurses will be responsible for verifying that fluids supplied to residents match the physician's order, particularly for residents requiring modified liquid consistencies, prior to serving. c. It was discussed with the licensed nurses the different liquid consistencies based on IDDSI, and they were given a copy of the IDDSI chart (Drinks/Liquids). All beverages requiring modified textures will be prepared in the kitchen. CNAs to verify the diet order using the diet list that will be in Nursing Station 1, Dining Room, and Activity Room prior to serving drinks/fluids. CNAs to verify liquid consistency and straw use with licensed nurses before serving residents requiring modified textures. 14. On 12/31/2025, the ST conducted an in-service training to licensed nurses present in the facility on the different types of 1DDSI fluid consistencies and testing methods. Staff on leave will receive in-service training upon return, provided by the ST or RD. 15. On 12/31/2025, the Assistant Administrator and the DSD conducted in-service training for non-nursing staff on the prohibition of providing food or fluids to residents. Non-nursing staff were instructed to communicate resident needs to licensed nursing staff. Non-nursing staff on leave will receive in-service training upon return, provided by the Assistant Administrator or designee. 16. Starting on 1/1/2026 the DON/Designee will conduct observations during breakfast, lunch, dinner, and snack times for residents requiring modified liquid consistencies (continued on next page)		

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F 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	food each diet would receive) titled Winter Menus, dated 12/29/2025, the spreadsheet indicated residents on puree diet/International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 would include the following foods on the tray: Puree three (3) bean chili 1 cup (c, a household measurement) Puree tossed green salad 1/3 c Puree cornbread with green chili 1/4 c Margarine with puree bread Pudding 1/3 c Milk 4 fluid ounces (oz, a unit of measurement) During a concurrent observation and interview on 12/29/2025 at 11:35 a.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate) with [NAME] 2, observed [NAME] 2 pouring liquid on the puree three bean chili without measuring it. [NAME] 2 stated she added a mixture of water, butter and chicken base to the puree bean chili. [NAME] 2 stated she checked the puree food every 15 minutes and added more liquid because it was too thick. [NAME] 2 added a total of 4 &frac34; cups of liquid to the puree 3 bean chili. During a concurrent observation and interview on 12/29/2025 at 11:45 a.m. with [NAME] 2, observed the preparation of the 3-bean chili. The puree 3 bean chili was observed to be flat on the plate. [NAME] 2 performed a spoon tilt test and added more liquid to the puree 3 bean chili. During an observation on 12/29/2025 at 12:01 p.m. of the puree 3 bean chili on the plate, the puree bean chili was observed to be flat on the tray when plated. During an observation on 12/29/2025 at 12:05 a.m. of [NAME] 1 mixing the puree 3 bean chili, observed [NAME] 1 adding water and thickener to the puree 3 bean chili. During an observation on 12/29/2025 at 12:08 p.m. of the first cart, five (5) puree diet trays with puree chili and puree season green beans were observed to be flat and had thin texture on the trays. During a concurrent observation and interview on 12/29/2025 at 12:11 p.m. of the puree 3 bean chili on trayline with the DS and [NAME] 2, observed the Dietary Supervisor (DS) telling the staff that the puree 3 bean chili was too thin when served on the plate. [NAME] 1 stated they would be adding slurry on the puree 3 bean chili and the DS was preparing it. The DS stated she prepared slurry which is composed of hot water and thickener. The DS stated they added a slurry to the puree 3 bean chili so that the puree consistency would be correct and not too thin. b. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 12/29/2025 at 12:40 p.m. with the DS, observed the DS performing a spoon tilt test on puree 3 bean chili and it had a thick puree food left on the spoon after tilting. The DS stated there was a thick film left on the spoon, but she needed to check her notes of the criteria when puree food passed the spoon tilt test. Observed the DS performed a spoon tilt test on the puree tossed green salad and it fell off the spoon quickly. The DS stated the puree tossed green salad was (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Grand Valley Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13524 Sherman Way Van Nuys, CA 91405	
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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 0805 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	too watery and too thin. The DS stated a standardized recipe was available for puree foods and the staff are supposed to follow it and not add liquid and thickener without measuring it. The DS stated if puree food was not in proper texture and consistency, residents would be unsatisfied with the food and would not eat it resulting in weight loss and choking as a potential outcome. During a review of the facility's diet manual titled IDDSI Framework reviewed on 8/25/2025, the manual indicated the facility has incorporated the IDDSI framework on its menus, recipes, spreadsheets, and supporting books. The IDDSI diet that will be available on facility's spreadsheets and recipe are as follows: IDDSI Level #4/Pureed- the pureed diet will consist of food that have been prepared in a manner to ensure the items served are smooth and free of lumps, hold their shape, without being too firm or sticky, and will not weep. The finished pureed food items, including sauces and gravies, must pass IDDSI level #4 testing requirements. IDDSI testing requirements: appearance, fork drip, and spoon tilt test. During a review of the facility's policies & procedure titled Food Preparation reviewed on 8/25/2025, the P&P indicated, the facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. During		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure the confidential personal information of residents were protected by failing to ensure documents (diet tickets) containing protected information ([PHI]- any health information that can be used to identify specific individual which must remain confidential to prevent harmful consequences) were shredded prior to disposing in the waste container. This failure had the potential to violate 80 of 82 residents' rights for privacy and confidentiality of personal and medical records. Findings: During an observation on 12/30/2025 at 3:36 p.m. of the dishwashing process with Dietary Aide 2 (DA 2), observed DA 2 sorting food and diet tickets from the soiled residents' tray in different trash containers. DA 2 threw the menu tickets in the trash. During an interview on 12/30/2025 at 3:43 p.m. with DA 2, DA 2 stated he separated food from diet tickets and napkins as they have a separate dumpster container. DA 2 stated the food goes to the food dumpster and the diet tickets and napkins go to trash dumpster. DA 2 stated he throws the diet tickets in the trash dumpster after washing dishes. During an interview on 12/30/2025 at 4:10 p.m. with the Dietary Supervisor (DS), the DS stated they have different dumpsters outside and one is for organic (food) and other one for plastic and paper. The DS stated they throw the diet tickets in the dumpster outside designated for paper and plastic. The DS stated the diet ticket contains information about residents' name, menu, diet, diet consistency, room number, food likes and dislikes and these are protected information. The DS stated it was not appropriate to throw the diet ticket in the trash because of Health Insurance Portability and Accountability Act ([HIPPA], a law that sets national standard to protect sensitive health information, making sure it stays private and secure) law and protection of data of privacy of residents. During a review of the facility's policy and procedure (P&P) titled Health Information Record dated 8/25/2025, the P&P indicated The facility will maintain systems/platforms that are secure, encrypted, and minimize the risk to resident privacy and confidentiality as per HIPPA/HITECH regulations and the Condition of Participation or Conditions of Coverage.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Three (3) medication errors out of 34 total opportunities contributed to an overall medication error rate of 8.82% affecting two of three residents (Resident 21 and 22) observed for medication administration. The medication errors were as follows: 1. For Resident 21: a. The facility failed to ensure that lidocaine 4% gel (a topical [applied to the skin] pain medication) was applied to Resident 21's left shoulder as ordered. b. The facility failed to ensure diclofenac sodium gel (a topical pain medication) was applied to the correct site when it was applied to Resident 21's left shoulder which was not a site indicated in the physician's order. 2. The facility failed to ensure Resident 22's metformin (medication to treat high blood sugar) medication was administered on time and with a meal per physician (MD) order. These failures had the potential to result in Resident 21 and 22 receiving suboptimal (less than standard) care, experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that medication may have) and resulting in Residents 21 and 22's health and well-being negatively impacted. Findings: 1. During a review of Resident 21's admission Record, the admission Record indicated the facility originally admitted the resident on 6/9/2022 and most recently readmitted the resident on 3/7/2025 with diagnoses including, but not limited to, urinary tract infection (UTI- an infection in the bladder/urinary tract), type 2 (chronic) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/18/2025, the MDS indicated the resident had moderately impaired cognition (trouble with thinking, learning, and remembering clearly). The MDS also indicated Resident 21 required moderate to substantial assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 21's Order Summary Report, the Order Summary Report indicated the following medications: a. Diclofenac sodium 1% external gel. Apply topically to bilateral knees two times a day for pain management. Apply four grams, dated 10/18/2023. b. Lidocaine 4% external gel. Apply to left shoulder, left arm topically two times a day for pain management, dated 3/14/23. During a concurrent observation and interview on 12/30/2025 at 8:07 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared diclofenac sodium 1% external gel and brought it into Resident 21's room. LVN 3 proceeded to apply the diclofenac sodium to Resident 21's bilateral knees and left shoulder. During an interview on 12/30/2025 at 12:02 p.m. with LVN 3, LVN 3 stated she thought diclofenac sodium was ordered to be applied to the resident's bilateral knees and the left shoulder, but after reviewing the resident's orders she stated diclofenac sodium should have been applied to the knees only and lidocaine gel to the left shoulder. During an interview on 12/31/2025 at 3:04 p.m. with the Director of Nursing (DON), the DON stated the doctor's orders should have been followed and lidocaine applied to the left shoulder instead of diclofenac sodium. The DON stated Resident 21 would not get the efficacy of lidocaine to her shoulder and applying diclofenac sodium to the shoulder may cause skin irritation and dermatitis (irritated, (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inflamed skin). During a review of the facility's policy and procedure (P&P) titled, Medication Administration, last reviewed 8/28/2025, the P&P indicated it is the policy of the facility that medications for residents be administered in a safe and timely manner, and as prescribed. The P&P indicated the licensed nurse administering the medication must check the label to verify the right resident, the right medication, the right dosage, the right time, and route of administration before giving the medication. 2. During a review of Resident 22's admission Record, the admission Record indicated the facility originally admitted on [DATE] and readmitted the resident on 4/30/2025 with diagnoses including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]). During review of Resident 22's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 11/5/2025, the MDS indicated Resident 22 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required maximal assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS also indicated Resident 22 was receiving hypoglycemic (types of medication that treats high blood sugar) medications. During a review of Resident 22's Order Summary Report, the Order Summary Report indicated an order dated 9/26/2025, for metformin hydrochloride (medication that helps control high blood sugar levels) extended release (ER) 500 milligrams (mg) by mouth (PO) two times a day for DM with meals. During a review of Resident 22's Administration History Report (AHR), metformin was scheduled to be administered daily at 7:15 a.m. and 5:15 p.m. The AHR indicated that metformin was administered on 12/30/2025 at 8:44 a.m. During a medication pass observation, and interview on 12/30/2025 at 8:27 a.m., with Licensed Vocational Nurse 1 (LVN 1), LVN 1 was observed administering metformin to Resident 22. LVN 1 confirmed that metformin was supposed to be administered with meals at 7:15 a.m. LVN 1 also stated that providing metformin late and without a meal could affect how the medication works and alter its absorption in the body. During an interview on 1/2/2026 at 11:01 a.m., with the Director of Nursing (DON), the DON stated that it was important to provide metformin at the right time and with meals as prescribed, since taking it at a different time or without food can affect absorption and cause significant changes in blood sugar levels. During a review a review of facility's policy and procedures (P&P) titled, Medication Administration, reviewed on 8/28/2025, the P&P indicated, the facility will administer medications for residents in a safe and timely manner. medications must be administered in accordance with the physician orders, including any required time frame.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed to follow the menu and meet the nutritional needs of the residents when [NAME] 1 did not follow the recipe for Puree 3 bean chili. This failure had the potential to result in decrease in food flavor, decrease in food and nutrient intake to 19 of 19 residents on Puree (foods that are smooth with pudding like consistency) /International Dysphagia Diet Standardization Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4, and puree consistent carbohydrate diet (diet consisting of the same amount of carbohydrates per meal for blood sugar management), resulting in increased blood sugar levels and unplanned weight loss. Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter Menus, dated 12/29/2025, the spreadsheet indicated residents on puree diet/IDDSI Level 4 would include the following foods on the tray: Puree three (3) bean chili 1 cup (c, a household measurement) Puree tossed green salad 1/3 c Puree cornbread with green chili 1/4 c Margarine with puree bread Pudding 1/3 c Milk 4 fluid ounces (oz, a unit of measurement) During a concurrent observation and interview on 12/29/2025 at 11:35 a.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate) with [NAME] 2, observed [NAME] 2 pouring liquid on the puree three bean chili without measuring it. [NAME] 2 stated she added a mixture of water, butter and chicken base to the puree 3 bean chili. [NAME] 2 stated she checked the puree food every 15 minutes and added more liquid because it was too thick. [NAME] 2 added a total of 4 3/4 cups of liquid to the puree 3 bean chili. During a concurrent observation and interview on 12/29/2025 at 11:45 a.m. of the preparation of the 3-bean chili with [NAME] 2, the puree 3 bean chili was observed to be flat on the plate. [NAME] 2 performed a spoon tilt test and added more liquid to the puree 3 bean chili. During an observation on 12/29/2025 at 12:01 a.m. of the puree 3 bean chili on the plate, the puree bean chili was observed to be flat on the tray when plated. During an observation on 12/29/2025 at 12:05 a.m. of [NAME] 1 mixing the puree 3 bean chili, observed [NAME] 1 adding water and thickener to the puree 3 bean chili. During an observation on 12/29/2025 at 12:08 p.m. of the first cart, observed five (5) puree diet trays had puree chili and puree season green beans were flat and had thin texture on the trays. During a concurrent observation and interview on 12/29/2025 at 12:11 p.m. of the puree 3 bean chili on trayline with the DS and [NAME] 2, observed the Dietary Supervisor (DS) telling the staff that the puree 3 bean chili was too thin when served on the plate. [NAME] 1 stated they would be adding slurry on the puree 3 bean chili and the DS was preparing it. The DS stated she prepared slurry which is composed of hot water and thickener. The DS stated they added a slurry to the puree 3 bean chili so that the puree consistency would be correct and not too thin. During an interview on 12/29/2025 at 1:07 p.m. with the DS, the DS stated it was important to follow standardized recipe and measure ingredients to ensure residents were not getting extra calories and carbohydrates for residents on puree, CCHO diet. The DS stated cooks kept adding extra thickener and chicken base with butter, CCHO diet was not followed and they are not compliant with the diet orders. The DS stated there would be changes in flavor resulting in residents not eating the food and weight loss. The DS stated possible weight gain would be the potential outcome of not following standardized recipes. During a review of the facility's policies & procedure titled Food Preparation dated 8/25/2025, the P&P indicated, the facility will use approved recipes, standardized to meet the resident census. This count is to be kept current so that an accurate amount of food is prepared. During a review of the facility's standardized recipe titled Recipe: 3 Bean Chili dated 2025, the recipe indicated there were no chicken base and butter in the recipe list. During a review of the facility's standardized recipe titled Recipe: Pureed (IDDSI Level #4) Soup dated 2025, the recipe indicated, ingredients: soup per recipe, crackers (saltine), if needed, stabilizer: instant potato, non-fat dry milk, breadcrumbs, toast, instant cream of rice or farina, or commercial instant food thickener. The recipe further indicated to (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prepare 24 servings would use 3/4 - 1 1/2 cups of thickener and chicken broth with butter and water were not included on the recipe list.		

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appearance, flavor and temperature for lunch when: Puree (foods that are soft with pudding like consistency) chili was flat on the plate and puree tossed salad was too watery. Puree tossed green salad's temperature was at 61 degrees Fahrenheit (F, a degree of temperature), puree Jello's temperature at 51 F, tossed green salad's temperature at 61 F, and citrus chiffon delight's temperature at 55 F during test tray (a process of tasting, temping, and evaluating the quality of food) These failures had potential to result in 80 of 82 facility residents at risk of unplanned weight loss, a consequence of poor food intake, from receiving getting food from the kitchen. Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Winter Menus, dated 12/29/2025, the spreadsheet indicated residents on puree diet/International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 would include the following foods on the tray: Puree three (3) bean chili 1 cup (c, a household measurement) Puree tossed green salad 1/3 c Puree cornbread with green chili 1/4 c Margarine with puree bread Pudding 1/3 c Milk 4 fluid ounces (oz, a unit of measurement) During a concurrent observation and interview on 12/29/2025 at 11:35 a.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate) with [NAME] 2, observed [NAME] 2 pouring liquid on the puree three bean chili without measuring it. [NAME] 2 stated she added a mixture of water, butter and chicken base to the puree bean chili. [NAME] 2 stated she checked the puree food every 15 minutes and added more liquid because it was too thick. [NAME] 2 added a total of 4 3/4 cups of liquid to the puree 3 bean chili. During a concurrent observation and interview on 12/29/2025 at 11:45 a.m. with [NAME] 2, observed the preparation of the 3-bean chili. Observed the puree 3 bean chili lay flat on the plate. [NAME] 2 performed a spoon tilt test and added more liquid to the puree 3 bean chili. During an observation on 12/29/2025 at 12:01 p.m. of the puree 3 bean chili on the plate, the puree bean chili was observed to be flat on the tray when plated. During an observation on 12/29/2025 at 12:05 p.m. of [NAME] 1 mixing the puree 3 bean chili, observed [NAME] 1 adding water and thickener to the puree 3 bean chili. During an observation on 12/29/2025 at 12:08 p.m. of the first cart, five (5) puree diet trays with puree chili and puree season green beans were observed to be flat and had thin texture on the trays. During a concurrent observation and interview on 12/29/2025 at 12:11 p.m. of the puree 3 bean chili on trayline with the DS and [NAME] 2, observed the Dietary Supervisor (DS) telling the staff that the puree 3 bean chili was too thin when served on the plate. [NAME] 1 stated they would be adding slurry on the puree 3 bean chili and the DS was preparing it. The DS stated she prepared slurry which is composed of hot water and thickener. The DS stated they added a slurry to the puree 3 bean chili so that the puree consistency would be correct and not too thin. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 12/29/2025 at 12:40 p.m. with the DS, observed the DS performing a spoon tilt test on puree 3 bean chili and it had a thick puree food left on the spoon after tilting. The DS stated there was a thick film left on the spoon, but she needed to check her notes of the criteria when puree food passed the spoon tilt test. Observed the DS performed a spoon tilt test on the puree tossed green salad and it fell off the spoon quickly. The DS stated the puree tossed green salad was too watery and too thin. The DS stated a standardized recipe was available for puree foods and the staff are supposed to follow it and not add liquid and thickener without measuring it. The DS stated if puree food was not in proper texture and consistency, residents would be unsatisfied with the food and would not eat it resulting in weight loss and choking as a potential outcome. During a review of the facility's diet manual titled IDDSI Framework dated 8/25/2025, the manual indicated the facility has incorporated the IDDSI framework on its menus, recipes, spreadsheets, and supporting books. The IDDSI diet that will be available on facility's spreadsheets and recipe are as follows: IDDSI (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Level #4/Pureed- the pureed diet will consist of food that have been prepared in a manner to ensure the items served are smooth and free of lumps, hold their shape, without being too firm or sticky, and will not weep. The finished pureed food items, including sauces and gravies, must pass IDDSI level #4 testing requirements. IDDSI testing requirements: appearance, fork drip, and spoon tilt test. 2. During a review of Resident 42's admission Record, the admission Record indicated the facility initially admitted Resident 42 on 12/2/2025 and readmitted on [DATE] with diagnosis including, but not limited to, dysphagia (difficulty swallowing), type 2 diabetes (too much sugar in the blood because the body cannot use insulin right away), and essential hypertension (high blood pressure). During a review of Resident 42's Minimum Data Sheet (MDS- a federally mandated resident assessment tool) dated 12/8/2025, the MDS indicated Resident 42 understood others and can make self-understood. The MDS indicated Resident 42 needed set up and clean up assistance (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) when eating. During a review of Resident 42's Order Summary Report, dated 1/20/2025, the Order Summary report indicated Resident 43 was ordered no added salt (NAS, no salt packet on the tray), consistent carbohydrate (CCHO, diet containing the same amount of carbohydrate each meal to manage blood sugar), easy to chew IDDSI Level 7 (diet that included food that are soft and tender in textures with the exclusion of hard, tough, chewy, fibrous, stingy, crunchy bits, pits, seeds, fibrous part of the fruit) regular texture, Level 0, thin liquid consistency. During a concurrent test tray observation and interview on 12/29/2025 at 12:23 p.m. of the puree diet tray with the DS at Station three (3), observed DS taking the temperature of the foods using the facility thermometer. The DS stated the following food had the following temperatures: Puree green tossed salad at 61 F, Puree Jello at 51 F During a concurrent test tray observation and interview on 12/29/2025 at 12:26 p.m. of the regular diet (diet with no restrictions) tray with the DS at Station 3, observed DS taking the temperature of the foods using the facility thermometer. The DS stated the following food had the following temperatures: Tossed green salad at 61 F Citrus chiffon delight at 55 F. During an interview on 12/30/2025 at 7:58 a.m. with Resident 42, Resident 42 stated the eggs and toast were cold this morning and he thinks they were the last ones to get their meals, so it was often cold. Resident 42 stated breakfast was the worst when it comes to cold foods, but lunch and dinner also come cold at times. During an interview on 12/30/2025 at 8:58 a.m. with the DS, the DS stated cold food should stay cold at 41 f and below before serving but when it comes out to the residents the acceptable temperature is 45 F and below for acceptability and palatability of food. The DS stated if temperatures are not acceptable, residents would not be acceptable to eat and residents would not eat the food resulting in decrease in food intake and weight loss. During a review of the facility's P&P titled Dietary- Menus, Food and Drink dated 8/25/2025, the P&P indicated It is the policy of the facility to meet needs of residents in accordance with established national guidelines. The facility will provide food and drink that is palatable, attractive and at safe and appetizing temperatures. The facility will prepare foods by methods that conserve nutritive value, flavor and appearance. During a review of the facility's P&P titled Dietary- Food and Nutrition Preparation and Service dated 8/25/2025, the P&P indicated It is the policy of the facility to provide each resident with nourishing, palatable, well-balanced diet that meets the daily nutritional and dietary needs.		

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NAME OF PROVIDER OR SUPPLIER Grand Valley Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13524 Sherman Way Van Nuys, CA 91405	
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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure Resident 20 received and consumed food in appropriate nutritive content as prescribed by a physician. This deficient practice had the potential to result in ineffective therapeutic diet, decreased in nutrient intake to one (Resident 20) of 82 residents, resulting in weight loss, getting food from the kitchen. Findings: During a review of Resident 20's admission Record, the admission record indicated the facility initially admitted Resident 20 on 9/16/2022 and readmitted on [DATE] with diagnosis including, but not limited to, moderate protein-calorie malnutrition (body lacks protein and energy for basic functions leading to noticeable weight loss, fatigue and muscle loss), type 2 diabetes (too much sugar in the blood because the body cannot use insulin right away), and essential hypertension (high blood pressure). During a review of Resident 20's Minimum Data Sheet (MDS - a federally mandated resident assessment tool) dated 11/15/2025, the MDS indicated Resident 20's usually understood others and rarely/never made self-understood. The MDS indicated Resident 20 needed supervision and touching assistance when eating (helper provides verbal cues and or touching/steadying and/or contact guard assistance as a resident completes the activity. Assistance maybe provided throughout the activity or intermittently). During a review of Resident 20's Order Summary Report, dated 11/18/2025, the Order Summary Report indicated Resident 20 was ordered no added salt (NAS, no salt packet on the tray), consistent carbohydrate diet (CCHO, diet containing the same amount of carbohydrate each meal to manage blood sugar), soft and bite sized texture (foods that are soft, tender and moist with no liquid separation that could be mashed or broken down with pressure from fork, spoon or chopstick), thin liquid consistency. During an observation on 12/29/2025 at 12:15 p.m. of the trayline (an area where foods were assembled from the steamtable to resident's plate), observed Resident 20 diet ticket indicated a diet of CCHO, NAS, soft bite sized (SB6), small portion. Observed an extra plate of chopped quesadilla had been prepared for Resident 20. During an interview on 12/29/2025 at 1:02 p.m. with the Dietary Supervisor (DS) the DS stated small portion diets received less portion compared to the regular portion diets and it depends what was indicated on the spreadsheet. The DS stated small portion diets are given to residents who were transitioning from tube feeding (tube that delivers nutrition, fluids, and medicine directly into the stomach through a tube placed through the abdomen) to regular food and those residents needing to lose weight. The DS stated if a resident was on small portion diet and got additional food on the plate, it could result in unplanned weight gain. During a review on 12/30/2025 at 10:39 a.m. of the Resident 20's physician diet order, the diet order indicated Resident 20's diet was NAS, CCHO, soft bite sized, regular thin liquid diet. During an interview on 12/30/2025 at 3:47 p.m. with the Registered Dietitian (RD), the RD stated that diet orders are ordered by a physician, nursing staff would fill up the duplicate slip indicating the diet of the resident and kitchen will get the original copy. The RD stated the diet order is placed by nursing in the order management system and it gets printed on the menu ticket every meal. The RD stated the diet order must match the menu ticket to avoid the risk of serving the wrong food to the residents and to ensure therapeutic diets are provided to residents as ordered. The RD stated a small portion diet is ordered by a physician for Resident 20's weight control and for some residents who stated meals are overwhelming. The RD stated if residents on regular portions received a small portion diet there could be a decreased in calorie intake necessary for maintenance of resident's nutritional status and weight loss, malnutrition and skin issues could result in decreased intake. During an interview on 12/30/2025 at 4:06 p.m. with the RD, the RD stated she changed the meal ticket of Resident 20 to match the diet order and the right portion was regular portion. The RD stated she changed meal ticket for dinner to avoid giving the wrong portion sizes of food to Resident 20. During a review of the facility's policies and procedures (P&P) titled Dietary-Menus, Food and Drink dated 8/25/2025, the P&P indicated, Each (continued on next page)		

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

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident will receive food in the appropriate form an/or the appropriate nutritive content as prescribed by their physician. During a review of the facility's P&P titled Diet Orders dated 8/25/2025, the P&P indicated Policy: Diet orders as prescribed by the physician will be provided by the Food and Nutrition Services department. Procedure: Nursing will send a Diet Order Communication slip to the food and Nutrition Services department. The FNS Director or [NAME] in charge will make or adjust the diet profile and tray card as prescribed. The diet count is also to be adjusted as needed. The diet profile and tray card will be removed upon discharge or transfer. Any discrepancy in the diet order slip will be clarified by the FNS director or cook in charge with nursing. During a review of the facility's P&P titled Portion Sizes dated 8/25/2025, the P&P indicated, Policy: Various portion sizes of the food served will be available to better meet the needs of the residents. Procedure: The small and large portion servings will be served as printed on the cook's spreadsheets for every meal. 1/2 size portions are to be given to those residents who request smaller portions than the small portion diet provides. This portion size is not recommended except with fortifications, as it may not meet the nutritional needs of most residents. The food server is to give the 1/2 size portion of the regular diet for the food on the main plate-entree, vegetable, and starch. Regular portions will be given for the soup, bread, salad, dessert, and beverage, unless otherwise stated by the Dietitian.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1, Kitchen equipment and utensils were not free from dirt, dust and food debris. a. Reach in refrigerators one (1), two (2), near the trayline (an area where foods were assembled from the steamtable to resident's plate) and four (4) had dirt, food, dust debris and buildup, juice spills on the shelves and gaskets. b. The toaster had breadcrumbs and burnt bread debris. c. The ice machine side bins had dirt buildup. 2. Milk in two (2) cups at 44 degrees Fahrenheit (F, a degree of temperature) and 43 F in the Reach in refrigerator 2. 3. The gasket on Reach-in refrigerator 2 was torn. 4. The Reach in refrigerator by trayline had no internal thermometer. 5. The dry storage floor had dirt, food and dust debris. 6. Four (4) dented cans were not separated with non-dented cans. 7. Chopping boards were stored along with red and green buckets containing chemical (sanitizer). 8. Fifty (50) of 80 residents' tray for dinner service on 12/30/2025 had no glaze and had cracks and chips. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 80 of 82 medically compromised residents who received food and ice from the kitchen. Findings: 1.a. During an observation on 12/29/2025 at 8:06 a.m. of the Reach-in refrigerator one (1), observed a food container with food debris and the side shelving on the reach in refrigerator had food debris. During an observation on 12/29/2025 at 8:15 a.m. of the Reach-in refrigerator two (2), observed gasket with dirt residues. During a concurrent observation and interview on 12/29/2025 at 8:22 a.m. of the Reach in-refrigerator 1 with the Dietary Supervisor (DS), the DS stated the cream cheese container and the side of the refrigerator had food debris and it could be sugar or bread. The DS stated the staff clean the refrigerator every Tuesday and Friday during the delivery of food and deep-clean it once a month. The DS stated last time it was cleaned was Friday. The DS stated it was not okay to have food debris in the refrigerator due to cross contamination of food. During a concurrent observation and interview on 12/29/2025 at 8:34 a.m. of the Reach-in refrigerator 2 with the DS, the DS stated the gasket had dirt and food debris and it was important to clean it to avoid cross-contamination. During an observation on 12/29/2025 at 8:40 a.m. of the reach-in refrigerator by trayline, observed dirt and food debris around the gasket. During a concurrent observation and interview on 12/29/2025 at 8:43 a.m. of Reach-in refrigerator four (4), observed the gasket with dirt and food debris. The DS stated the gasket needed to be clean as it had dirt and food debris to prevent cross-contamination. During an observation on 12/29/2025 at 8:54 a.m. of the Reach-in freezer 1, observed dirt debris on the freezer shelves. During an observation on 12/29/2025 at 8:57 a.m. of the Reach-in freezer 2, observed dirt and food debris on the shelves and gasket. During an interview on 12/29/2025 at 9:02 a.m. with the DS, the DS stated two (2) employees were assigned to clean the refrigerators and freezers, but they were not focused on cleaning the refrigerator and gaskets. The DS stated Reach-in freezer 1 and Reach-in freezer 2 had dirt buildup, food debris and spill and it was not okay because it could cause cross-contamination. The DS stated foodborne illnesses to the residents could be the potential outcome of cross-contamination. During a review of the facility's policies and procedures (P&P) titled Procedure for Refrigerated Storage dated 8/25/2025, the P&P indicated Refrigeration equipment should be routinely cleaned. During a review of the facility's P&P titled Refrigerator and Freezer dated 8/25/2025, the P&P indicated Maintaining a clean refrigerator and freezer can improve the safety and quality of your foods. Food the best cleaning results, always refer to your owner's manual. (1) Refrigerator and freezer should be on a weekly cleaning schedule (2) Wipe up spills immediately. (5) Wipe down gaskets with soapy water. (6) Remove all items and clean shelves. Wipe with sanitizer. b. During an observation on 12/30/2024 at 3:17 p.m. of the toaster, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed breadcrumbs debris and a burnt piece of bread inside the toaster. During a concurrent observation and interview on 12/30/2025 at 3:17 a.m. of the toaster with [NAME] 2, [NAME] 2 stated the toaster should be cleaned after each use and she needed to remove the screw so they could clean the toaster as it had breadcrumbs inside it. [NAME] 2 stated it is important to maintain the cleanliness of the toaster to prevent cross-contamination. During an interview on 12/30/2025 at 4:06 p.m. with the DS, the DS stated they clean the toaster once a week and every after use. The DS stated the paint from the toaster was coming off and it is time to change it due to physical hazard and contamination. The DS stated bacteria can grow in the food and residents could get sick from it. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. c. During a concurrent observation and interview on 12/31/2025 at 11:08 a.m. of the ice machine internal parts in the room across room [ROOM NUMBER] with the DS, the ice machine internal parts had dirt residue on the side. The DS stated dirt in the ice machine was not good as it could contaminate the ice and residents could get illness from the dirt and mold. During a concurrent observation and interview on 12/31/2025 at 11:20 a.m. of the internal part of the ice machine with the Maintenance Supervisor (MS), the MS stated the side of the ice machine internal part had dirt debris and it needed to be removed and clean. The MS stated the ice machine should be free from dirt and mold debris to keep the residents safe as they could get upset stomachs as a potential outcome. During a review of the facility's P&P titled Cleaning the Ice Machine dated 8/25/2025, the P&P indicated The ice machine shall be cleaned for maintenance of sanitary conditions in order to prevent food contamination and the growth of disease-producing organisms and toxins. The ice machine shall be cleaned in accordance with the manufacturer's requirements. The ice machine shall be cleaned using a nickel safe ice machine cleaner and sanitized every month per manufacturer's guidelines. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At any time when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.12 Cooking and Baking Equipment. (A) The food contact surfaces of cooking and baking equipment shall be cleaned at least every 24 hours. This section does not apply to hot oil cooking and filtering equipment if it is cleaned as specified subparagraph 4-602.11 (D)(6). During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 2. During an observation on 12/29/2025 at 8:15 a.m. of the milk in the cup in the Reach-in refrigerator 2, observed the temperature of the milk was at 44 F. During a concurrent observation and interview on 12/29/2025 at 8:28 a.m. of the milk in the cups with the DS, observed DS took the temperature of the milk in the cups. The DS stated the milk temperature was 44.4 F for one cup and 45 F for the other cup. The DS stated the milk was poured in the cup in the preparation area at 7:15 a.m. The DS stated the milk (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would not be acceptable to serve to the residents, but the staff just prepared the milk, and the temperature should go down to 40 F and below at 9:15 a.m. The DS stated it was important for the milk not to be in the danger zone ([41 F-135 F], the range of temperature where bacteria multiply and grow rapidly), to avoid the growth of microorganisms and foodborne illnesses. During a concurrent observation and interview on 12/29/2025 at 9:22 a.m. of the milk temperature in the Reach-in refrigerator 2 with the DS, the DS took the temperature of the milk in the cup. The DS stated the cups of milk were at 43 F and 44 F and it would not be okay to serve the milk as it was in the danger zone, and the temperature did not go down in 2 hours. The DS stated they will toss the milk in the cups and prepare a new one. During review of the facility's P&P titled Food Temperatures dated 8/25/2025, the P&P indicated Cold food should be served at 41 F or below. Potentially hazardous food has been held above proper temperatures for more than two hours; they should be discarded. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.16 Time/Temperature for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as a public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, Time/Temperature Control for safety food shall be maintained: (2) At 5 C (41 F) or less. 3. During an observation on 12/29/2025 at 8:15 a.m. of the Reach-in refrigerator 2, observed the bottom gasket was torn. During a concurrent observation and interview on 12/29/2025 at 8:34 a.m. of the Reach-in refrigerator 2's gasket with the DS, the DS stated the gasket was torn and needed to be replaced. The DS stated the expectation was to have a good fitting refrigerator gasket so that the refrigerator could be close to ensure the inside temperature is correct. The DS stated if the inside refrigerator's temperature was not kept in the acceptable temperature, the refrigerator would be in the danger zone, and the food could spoil. The DS stated there would be a potential foodborne illness upon consumption of spoiled food for the residents. During a review of the facility's P&P titled Refrigerator and Freezer dated 8/25/2025, the P&P indicated How to keep your refrigerator and freezer working efficiently: (2) Periodically, check door gaskets and replaced if damaged. 4. During an observation on 12/29/2025 at 8:40 a.m. of the Reach-in refrigerator by trayline, observed no thermometer inside the refrigerator. During an interview on 12/29/2025 at 8:43 a.m. with the DS, the DS stated there should be two (2) thermometers in all the refrigerators, one for in the inside and one external to make sure the refrigerator works for temperature maintenance. During a review of the facility's P&P titled Procedure for Refrigerated Storage dated 8/25/2025, the P&P indicated (2) Two thermometers, placed to be easily visible for checking, should be inside all walk-in, reach-in refrigerators. The second thermometer is check against the first thermometer for accuracy. A temperature will be logged twice daily by a designated employee upon opening of the kitchen and upon closing of the kitchen. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot FOOD storage unit. (B) Except as specified in (C) of this section, cold or hot holding equipment used for time/temperature control for safety food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display. 5. During an observation on 12/29/2025 at 9:04 a.m. of the dry storage area, observed dirt, food, dust on the floor under the storage shelves. During an interview on 12/29/2025 at 9:09 a.m. with the DS, the DS stated storage floors had dirt and food debris and staff needed to clean all the way at the back of the shelves. The DS stated it was important to maintain cleanliness of the food storage area due to cross-contamination and growth of pathogens that could cause foodborne illnesses to the residents and for pest control. During a review of the facility's P&P titled Storeroom dated 8/25/2025, the P&P indicated The general cleanliness and care of the storeroom and supplies are important to ensure safe wholesome food. (1) The floor, walls, ceiling, lights, shelves and equipment must be kept clean by (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	setting up, maintaining, and monitoring a regular cleaning schedule. Routine inspection must be made to ensure cleanliness and high standards of sanitation. (Refer to shelves, walls, ceiling and floor cleaning). During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 6. During an observation on 12/29/2025 at 9:04 a.m. observed four (4) dented cans stored with non-dented cans. During an interview on 12/29/2025 at 9:12 a.m. with the DS, the DS stated dented cans are separated and placed in the bottom shelves to be returned to vendor. The DS stated the cans are considered dented if your thumb can fit in the dent or if the dent is inside or in the can opening where bacteria could go in. The DS stated they separate dented cans because they could not use them due to bacteria oxidizing food for bacterial growth. The DS stated if residents consume the dented can food, they could get foodborne illnesses as a potential outcome. The DS stated there were 4 dented cans on the shelves where undented cans were stored and it should not be there. During a review of the facility's P&P titled Food Storage-Dented Cans dated 8/25/2025, the P&P indicated Policy: Food in unlabeled, rusty, leaking, broken containers or cans with side seam dents, rim dents or swells shall not be retained or used by the facility. Procedure: All dented cans (defined as side seam or rim dents) and rusty cans are to be separated from remaining stock and placed in a specified labeled area for return to purveyor for refund. All leaking cans are to be disposed of immediately. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of 3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 7. During an observation on 12/30/2025 at 3:13 p.m. of the chopping board storage area, observed chopping boards were stored along with red and green buckets with chemical without a physical barrier. During a concurrent observation and interview on 12/31/2025 at 10:53 a.m. of the chopping board storage with the DS, the DS stated the green and red buckets should not be close to the clean chopping board because of cross-contamination. The DS stated the buckets contained sanitizer and water that could spill on the clean chopping board hence they have to move the buckets to another area. During a review of the facility's P&P titled Personal Hygiene dated 8/25/2025, the P&P indicated Cross-contamination: Keep food surfaces sanitized. Food surfaces include cutting boards, tableware, knives, and other utensils used to prepare foods. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 8. During an observation on 12/30/2025 at 3:32 p.m. of the resident's tray assembled in the racks for dinner use, 50 of 80 residents' trays were observed to have no glaze and were cracked and chipped. During an interview on 12/30/2025 at 4:09 p.m. with the DS, the DS stated the trays are chipped and needed to be replaced. The DS stated the trays must be smooth and free of chips to ensure proper meal presentation for residents. The DS stated the chipped surfaces could harbor bacteria, increasing the risk of infection. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly by failing to ensure: 1. Two (2) of 2 black dumpsters (a movable waste container designed to be brought and taken away by a special collection vehicle, or to a bin that a specially designed garbage truck lifts) were completely closed while not actively being used. 2. There were no soiled gloves, masks, and a bag of trash on the floor area and surroundings of the facility's dumpster. 3. The dumpster designated for food and organic waste was not leaking fluid on the ground. These failures had potential to attract birds, flies, insects, pests, and possibly spread infection to 82 of 82 facility residents. Findings: During an observation on 12/30/2025 at 4:15 p.m., of the dumpster area with the Dietary Supervisor (DS), observed two (2) black dumpsters that were not completely closed and there was a bag of trash, soiled gloves, plastic, mask, and paper on the floor and the surroundings of the dumpster. During an observation on 12/30/2025 at 4:16 p.m., of the dumpster designated for food with the DS, observed liquid drippings on the base of the dumpster. During an interview on 12/31/2025 at 10:56 a.m., with the DS, the DS stated all the trash must be inside the dumpster and they cannot leave a trash bag on the floor and the dumpster lids should always be closed. The DS stated dumpster surroundings must be cleaned and free of trash for infection control and to avoid animals and pests getting into the trash. The DS stated animals and pests could come inside the facility and contaminate the food residents would receive. The DS stated it was not acceptable that the dumpster lids were open yesterday, that there was trash around the surrounding area, and there was a leak of fluid in the dumpster designated for food because it could attract pests and animals. The DS stated the dietary staff are responsible for keeping the dumpster lid close. During a review of the facility's policy and procedure (P&P) titled, Sanitation and Infection Control-Waste Control and Disposal, dated 8/25/2025, the P&P indicated It is the policy of the facility to use proper procedures for waste control and disposal. Procedures: Keep lids of outside trash dumpster closed. Outside trash compactors require a protective cover to prevent pests, animals or debris from falling in. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.15 Outside receptacles. (A) Receptacles and waste handling units for REFUSE, recyclables, and returnable used with materials containing FOOD residue and used outside the FOOD ESTABLISHMENT shall be designed and constructed to have tight-fitting lids, doors, or covers. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. An unopened box of expired lancets (tiny, sharp needles used to prick the skin to obtain a small blood sample for blood glucose [sugar] monitoring) found in one of one medication storage room was disposed of on the date of expiration This deficient practice had the potential to cause an infection if the expired lancets were used on a resident. 2. One of three sampled resident's (Resident 21) insulin pen (a device used to administer insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication]) tip was not cleaned with an alcohol pad prior to attaching the needle. This failure had the potential to increase Resident 21's risk of developing an infection at the site of the injection. Findings: a. During a concurrent observation and interview on [DATE] at 4:15 p.m., with Registered Nurse 1 (RN 1), observed inside the medication storage room, one unopened box of expired ACCU-CHEK Softclix lancets on the shelf with the expiration date of [DATE]. RN 1 stated the lancets needed to be disposed of because they could cause infection if not used before the expiration date. RN 1 then disposed of the unopened box of lancets. During an interview on [DATE] at 4:40 p.m., with the Director of Nursing (DON), the DON stated the expired box of lancets could cause infection because there is no way of verifying if the lancets are still sterile and safe to use. During a review of the facility's insert for ACCU-CHEK Softclix lancets, dated 2024, the insert indicated, Risk of Infection . If the use by date of the lancet has expired, the lancet can be unsterile. Insert only lancets that are within the use by date. During a review of the facility's policy and procedure (P&P) titled, Equipment and Supplies for Administering Medications, dated [DATE], the P&P indicated, The facility maintains equipment and supplies necessary for the preparation and administration of medications to residents. b. During a review of Resident 21's admission Record, the admission Record indicated the facility originally admitted the resident on [DATE] and most recently readmitted the resident on [DATE] with diagnoses including, but not limited to, urinary tract infection (UTI- an infection in the bladder/urinary tract), type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated the resident had moderately impaired cognition (trouble with thinking, learning, and remembering clearly). The MDS also indicated Resident 21 required moderate to substantial assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 21's care plan (a document summarizing a resident's health conditions, care needs, goals, and treatments) titled, Resident Care Plan: Diabetes Mellitus, dated [DATE], the care plan indicated an intervention to practice infection/universal precautions while administering skin punctures. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 21's Order Summary Report, the Order Summary Report indicated an order to inject nine (9) units of Lantus (a type of insulin that works steadily over 24 hours to help the body absorb glucose) subcutaneous (to be injected under the skin) solution two times a day for diabetes mellitus, dated [DATE]. During a concurrent medication administration observation and interview on [DATE] at 8:07 a.m., with Licensed Vocational Nurse 3 (LVN 3), LVN 3 removed Resident 21's insulin Lantus SoloStar pen (a brand name of an insulin pen) from the medication cart and attached a needle to the tip of the pen. LVN 3 did not scrub the end of the insulin pen with alcohol prior to attaching the needle. LVN 3 stated she cleans the vials of insulin with alcohol prior to using a needle to draw up insulin but did not clean the insulin pen. LVN 3 stated she should have cleaned the insulin pen tip with alcohol prior to attaching the needle. LVN 3 stated without cleaning with alcohol first, germs could get to the patient which could cause an infection. During an interview on [DATE] at 3:04 p.m., with the DON, the DON stated insulin pen tips should be wiped with alcohol before putting on the needle as there is a risk of infection to the resident. During a review of the facility's policy and procedure (P&P) titled, Infection Control & Medical Device Safety, last reviewed [DATE], the P&P indicated it is the policy of the facility that staff implement and comply with infection control policies and procedures for medical device safety, which includes administration of medications. The P&P indicated injectable medications should be prepared using aseptic technique (purposeful prevention of microbe contamination from one person or object to another) in a clean area free from potential sources of infection. During a review of the facility-provided Lantus SoloStar pen manufacturer's instructions, (undated), the manufacturer's instructions indicated to wipe the pen tip (rubber seal) with an alcohol swab before screwing on a new needle.		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the food services department when one dead cockroach (a type of insect) was observed in the residents' refrigerator in the staff break room. This failure had the potential to result in 80 of 82 residents, who received food from the kitchen, acquiring food borne illnesses (illness caused by consuming contaminated foods or beverages) by consuming potentially contaminated food. Findings: During a concurrent observation and interview on 12/31/2025 at 11:28 a.m., with the Dietary Supervisor (DS), observed the residents' refrigerator in the staff break room. Observed there was a resident's food stored inside the refrigerator and one (1) dead cockroach inside the vegetable bin. The vegetable bin was difficult to remove because a bench chair and another refrigerator were blocking the refrigerator door from completely opening. The DS stated the brown insect looked like a dead cockroach. During a concurrent observation and interview on 12/31/2025 at 11:31 a.m., with the Housekeeping Supervisor (HKS), observed the resident's refrigerator. The HKS stated she (HSK) cleaned the refrigerator in the morning. The HKS stated there were dead cockroaches in the refrigerator and she cannot even clean it because the door would not completely open. The HKS stated it was not acceptable to have dead cockroaches in the residents' refrigerator because there was a resident's food stored in there. The HKS stated it is important to maintain the residents' refrigerator free of pest for infection control. During an interview on 12/31/2025 at 11:47 a.m., with Licensed Vocational Nurse 4 (LVN 4) and Infection Prevention Nurse (IPN), LVN 4 stated they ensure that everything is sanitary and clean in the residents' refrigerator because it could compromise residents' health. The IPN stated the potential outcome for pests in the refrigerator is infection spread to the residents. During a review of the facility's policy and procedure (P&P) titled, Pest Control, dated 8/25/2025, the P&P indicated, It is the policy of the facility that pest will be managed utilizing a pest management company. During a review of the facility's pest control report titled, Service Report, dated 10/10/2025, the report indicated there was German roach inside the employee break room and was treated. During a review of the facility's pest control report titled, Service Report, dated 12/23/2025, the report indicated high activity of fungus gnats (slender and delicate fly) in the breakroom area, and it was treated. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 6.501.111 Controlling Pests. The premises shall be maintained free of insects, rodents and other pests shall be controlled to eliminate their presence on the premises by: - Routinely inspecting incoming shipments of food and supplies. - Routinely inspecting the premises for evidence of pests. - Using methods, if pests are found, such as trapping devices or other means of pest control specified under SS 7-202.12, 7-206.12, and 7-206.13. - Eliminating harborage conditions.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to ensure Licensed Vocational Nurse (LVN 5) knocked on a resident's door and requested permission before entering the room for one of two sampled resident (Resident 114) reviewed under the dignity care area. This deficient practice violated the resident's rights to be treated with respect and dignity, which had the potential to affect the resident's sense of self-worth and self-esteem. ^ Findings: ^ During a review of Resident 114's admission Record, the admission Record indicated the facility admitted the resident on 12/17/2025 with diagnoses including muscle weakness and type 2 diabetes mellitus (a group of diseases that result in too much sugar in the blood). ^ During a review of Resident 114's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/23/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and sense) skills for daily decision making were intact. The MDS indicated that Resident 114 required assistance in performing activities of daily (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). ^ During a concurrent observation and interview on 12/29/2025 9:51 a.m., observed LVN 5 wheel the medication cart outside of Resident 114's room. LVN 5 then went inside the resident's room without knocking and asking permission from the resident. LVN 5 then stepped out of the resident room, placed a blood pressure machine on top of the medication cart and went back to the resident's room without knocking and asking permission from the resident. LVN 5 then came out of the room and started to pour medications on a medicine cup and went back to the resident room (3rd time) with the medications without knocking and asking permission from the resident. LVN 5 was asked if it was appropriate to go in the resident's room without knocking and asking permission from the resident, LVN 5 stated that he should have knocked, introduced himself and asked permission from the resident before entering the room. LVN 5 stated knocking before entering the room helps prevent the resident from being startled and shows respect for their personal space. During a review of the facility's policy and procedure (P&P), titled, Resident's Right to Dignity and Privacy, last reviewed on 8/28/2025, the P&P indicated, It is the policy of the facility that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality and provides for resident privacy.residents private space and property shall be respected at all times; staff will knock and request permission before entering a resident's room.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care and services facility staff need to provide a resident to promote healing and prevent a worsening of a condition, and current treatments) for one of three residents (Resident 11) reviewed under the accidents care area by failing to indicate in the care plan titled, Impaired Physical Mobility and Self-Care Deficit, dated 1/08/2025, the required level of assistance needed to safely transfer Resident 56 from the bed to the and from wheelchair back to the bed. This deficient practice had the potential to place Resident 11 at risk for injuries. Findings: During a review of Resident 11's admission Record (AR), the AR indicated that the facility initially admitted the resident on 6/21/2024 and readmitted the resident on 4/28/2025 with diagnoses including muscle weakness and presence of artificial knee joint. During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 9/25/2025, the MDS indicated that the resident's cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reasonable). The MDS further indicated that Resident 11 was dependent on assistance of two or more helpers for activities of daily living (ADL-activities related to personal care) and totally dependent on staff for chair/bed-to-chair transfer. During a concurrent interview and record review on 12/30/2025 at 1:55 p.m., with the Minimum Data Set Nurse Assistant (MDSNA), reviewed Resident 11's Care Plan (CP) titled, Impaired Physical Mobility and Self-Care deficit, dated 1/08/2025. The CP indicated an intervention to assist with ADL as necessary and to provide assistance during transfer in and out of bed, wheelchair, toilet and vice versa (the other way around) using appropriate device as needed. The MDSNA stated the CP did not specify the required number of staff necessary to assist the resident with safe transfers in and out of bed. The MDSNA stated that based on the MDS assessment dated [DATE], the resident required two-person assistance with transfers, however, the CP did not indicate this level of assistance. During an interview on 12/30/2025 at 3:58 p.m., with Certified Nurse Assistant 2 (CNA 2). CNA 2 stated that when transferring a resident from the bed to the chair and vice versa, sometimes it is done with one person assistance but when using a mechanical lift (a full body, electric patient lift capable of lifting from the floor), two people should assist the resident to prevent accidental fall. CNA 2 stated that the level of assistance a resident requires with transfers is indicated in the resident's care plan. During a review of the facility's policy and procedures (P&P) titled, Fall Risk & Prevention of Injury to include Pathological Fractures, last reviewed on 8/28/2025, the P&P indicated that It is the policy of the facility to identify residents that are at risk for falls and implement a plan of care in an attempt to prevent falls. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Planning, last reviewed on 8/28/2025, the P&P indicated that It is the policy of this facility that a comprehensive resident-centered care plan be developed for each resident that includes measurable objectives and timeframes to meet each resident's medical, nursing and mental and psychosocial needs that are identified in the comprehensive assessment. ^		

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review, the facility failed to implement its policy and procedure titled Residents Who Present with Communication Barriers, by failing to provide a communication device or board (a tool that includes pictures that help residents communicate their healthcare and every-day needs to facility staff) in their preferred language for one of two sampled residents (Resident 55) reviewed under the communication-sensory care area. This deficient practice had the potential to prevent the resident from communicating with the staff and receiving care in a timely manner. Findings: During a review of Resident 55's admission Record, the admission Record indicated that the facility admitted the resident on 7/18/2025, with diagnoses including muscle weakness and dysphagia (difficulty swallowing). During a review of the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 10/23/2025, the MDS indicated Resident 55's preferred language is not English and needed an interpreter to communicate with a doctor or health care staff. The MDS indicated that the resident had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses). The MDS indicated Resident 55 required substantial/maximal assistance (the resident performed part of the activity, but staff provided more than half of the effort needed to complete the activity or two or more staff were required to assist) with toileting hygiene, shower, lower body dressing, and putting on and taking off footwear. During a concurrent observation and interview on 12/30/25 at 9:26 a.m. with the Infection Preventionist Nurse (IPN), in Resident 55's room, there was no communication board observed at the resident's bedside. The IPN stated that the social services department is responsible for assisting residents with communication needs when the resident's primary language is not English. During an interview on 12/30/2025 at 12:45 p.m. with the Social Services Director (SSD), the SSD stated that her department is responsible for assessing the communication needs of residents who are non-English speakers. The SSD stated that it is very important for the residents with a language barrier to be able to communicate their needs using a communication board. The SSD stated that if a resident has no way of communicating their needs it can result in frustration and unmet needs. During a review of Resident 55's Care Plan (CP, a document that outlines how a patient's health care needs will be met) dated 11/06/2025, the CP indicated a problem of impaired communication secondary to language barrier, with a goal that the resident will communicate effectively despite language barrier with the use of translator, gestures and communication board daily. During a review of the facility's policy and procedures (P&P) titled, Residents Who Presents With Communication Barriers, last reviewed on 8/28/2025, the P&P indicated that It is the policy of this facility to meet the needs of residents who present with communication barriers. Communication boards will be provided at no charge to the resident so that non-English speakers, or aphasic residents can use pictograms to communicate needs and desires.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review, the facility failed to draw a resident's hemoglobin (Hgb, is the iron-rich protein in red blood cells that carries oxygen) and hematocrit, (Hct, is the percentage of the total blood volume made up of red blood cells) as indicated in the physician's order for one (Resident 4) of five residents investigated for unnecessary medications. This had the potential for residents to suffer side effects from having low blood counts such as dizziness and syncope (fainting). Findings: During a review of Resident 4's admission Record (or Facesheet, the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 4's Census (the document that indicates when a resident goes and returns from a general acute care hospital [or simply hospital]), the census indicated Resident 4 returned from a GACH on 10/25/2025. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 11/22/2025, the MDS indicated Resident 4 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort) with eating, oral hygiene, and upper body dressing. During a review of Resident 4's Physician's Orders, the Physician's Orders indicated an order to draw the laboratory values for hemoglobin (Hgb, is the iron-rich protein in red blood cells that carries oxygen) and hematocrit, (Hct, is the percentage of the total blood volume made up of red blood cells) level every two weeks on Fridays, dated 10/27/2025. During a review of Resident 4's Physician's Orders, the Physician's Orders indicated an order for epoetin alfa-EPBX (also known as Retacrit, the brand name, which is given to treat anemia) 4000 units per milliliter (unit/ml, a unit of measure for Retacrit), inject 1 ml subcutaneously (to be given by injection into the fat below the skin) one time a day every Monday for anemia until 12/01/2025, hold dose if Hgb is greater than (>) 11 grams per deciliter (g/dL, a unit of measure for measuring red blood cells, normal reference range is 11.0 - 16.0 g/dL). During a review of Resident 4's Laboratory Values (labs), the laboratory values indicated Resident 4's Hgb and Hct were drawn on the following dates: 10/31/2025, 11/14/2025, 11/28/2025, and 12/05/2025. There was no documentation indicating labs were drawn on 12/12/2025 or 12/26/2025. During a review of Resident 4's Care Plan for Anemia, initiated 10/25/2025, the care plan indicated a goal that the Hgb and Hct level will be within normal (sic) when checked. The care plan indicated an intervention to draw the Hgb and Hct levels every two weeks. During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN) on 12/30/2025 at 3:15 p.m., the MDSN reviewed Resident 4's lab values. The MDSN confirmed that there were no labs for Hgb or Hct drawn on 12/12/2025 or 12/26/2025. The MDSN stated the labs should have been drawn, according to the order. The MDSN stated the licensed nurses should have clarified with Resident 4's physician to find out if those labs still needed to be drawn. The MDSN stated it is important to follow-up with the physician because Resident 4 could be at risk for anemia or any internal bleeding. During an interview with the Assistant Director of Nursing (ADON) on 12/30/2025 at 5:16 p.m., the ADON stated Resident 4's physician should have been contacted to see if the resident still needed the labs to be drawn. During an interview with the Director of Nursing (DON) on 1/02/2026 at 10:30 a.m., the DON stated Resident 4's physician should have been contacted prior to the labs that were to be drawn 12/12/2025 to see if Resident 4 still needed them. The DON stated this was important because a low Hgb/Hct lab value could cause anemia with adverse effects of dizziness, syncope, abnormal vital signs, placing them at risk for hospitalization and in need of blood transfusion. During a review of the facility's policy and procedure (P&P) titled, Physician Services, last reviewed on 8/28/2025, the P&P indicated drugs, biologicals, laboratory services, radiology and other diagnostic services shall be (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Grand Valley Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 13524 Sherman Way Van Nuys, CA 91405	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered or performed only upon the written order of a person duly licensed and authorized to prescribe such drugs and services. The policy and procedure indicated this person is a resident's physician.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain an environment free from potential accident hazards for one of three residents (Resident 21) observed during medication administration when Resident 21's medications were left unattended at the resident's bedside. This deficient practice had the potential to result in an unsafe medication administration to Resident 21. Findings: During a review of Resident 21's admission Record, the admission Record indicated the facility originally admitted the resident on 6/9/2022 and most recently readmitted the resident on 3/7/2025 with diagnoses including, but not limited to, urinary tract infection (UTI- an infection in the bladder/urinary tract), type 2 (chronic) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 21's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 11/18/2025, the MDS indicated the resident had moderately impaired cognition (trouble with thinking, learning, and remembering clearly). The MDS also indicated Resident 21 required moderate to substantial assistance with most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 21's Order Summary Report, the Order Summary Report indicated the following medications: 1. Amlodipine (a medication that treats high blood pressure and chest pain) 5 milligram (mg) tablet. Give one tablet every morning for hypertension (high blood pressure), dated 3/2/2023. 2. Buspirone (a medication that treats anxiety) 15 mg tablet. Give one tablet every morning for anxiety manifested by expressing excessive worry about health, dated 4/27/2023. 3. Colace (stool softener) 100 mg capsule. Give one capsule two times a day for bowel management, dated 7/31/2024. 4. D-Mannose (a supplement used for urinary tract health) 500 mg capsule. Give two capsules two times a day to prevent UTIs, dated 3/10/2025. 5. Diclofenac sodium (a topical [applied to the skin] pain medication) 1% external gel. Apply topically to bilateral knees two times a day for pain management. Apply four grams, dated 10/18/2023. 6. Drizalma Sprinkle (a medication used for depression and certain types of pain) 60 mg capsule. Give one capsule two times a day for pain management, dated 4/28/2025. 7. Gabapentin (a medication used to treat seizures and pain) 100 mg capsule. Give two capsules three times a day for neuropathic (affects the nerves) pain, dated 8/1/2023. 8. L-Methylfolate (a vitamin) 7.5 mg tablet. Give one tablet in the mornings for anemia (a condition where the body does not have enough healthy red blood cells), dated 10/18/2023. 9. Lantus (a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] that works steadily over 24 hours) Subcutaneous (to be injected under the skin) solution. Inject two times a day for diabetes mellitus, dated 9/18/2025. 10. Losartan (a medication used to treat high blood pressure) 100 mg tablet. Take one tablet daily for hypertension, dated 3/1/2023. 11. Namenda (a medication used to treat moderate to severe dementia) 10 mg tablet. Give one tablet two times a day for dementia, dated 6/28/2023. 12. Plavix (a blood thinner) 75 mg tablet. Give one tablet daily for transient ischemic attack (TIA, a mini stroke) prevention, dated 3/1/2023. 13. Refresh Tears 0.5% ophthalmic (to be used in the eyes) solution. Give one drop to both eyes four times a day for dry eyes, dated 10/17/2024. 14. Vitamin B complex Oral Tablet. Give one tablet daily in the morning for supplement, dated 3/21/2024. During a concurrent observation and interview on 12/30/2025 at 8:07 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 prepared the following medications and brought them into the Resident 21's room: amlodipine, buspirone, D-Mannose, diclofenac sodium, Drizalma Spinkle, gabapentin, L-Methylfolate, Lantus insulin pen (a device used to administer insulin), losartan, Namenda, Plavix, Refresh Tears, and vitamin B complex. LVN 3 set the medications on the resident's bedside table then left them unattended and out of eyesight while she went back to the medication cart. LVN 3 stated she went back to the medication cart because she forgot to bring in the resident's Colace capsule. LVN 3 stated she should have taken (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all the medications with her when she left to get the Colace capsule. LVN 3 stated the medications should not be left unattended with the resident because something could happen like the resident knocking the medications over, the resident could take some of the medication and she would not see it and know exactly what she did take, or someone else could come in and take them. During an interview on 12/31/2025 at 3:04 p.m. with the Director of Nursing (DON), the DON stated Resident 21 is not able to safely self-administer medications. The DON stated the best practice is for a licensed nurse to not leave any medications out of eyesight due to safety issues. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, last reviewed 8/28/2025, the P&P indicated it is the policy of the facility that medications for residents be administered in a safe and timely manner, and as prescribed. During a review of the facility's P&P titled, Safety and Supervision of Residents, last reviewed 8/28/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible.		

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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 (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTI, common infections that happen when bacteria infect the urinary tract) by failing to ensure the urinary catheter (a thin flexible tube that is inserted into the bladder to help drain urine) collection bag tubing was not looped or coiled to allow the urine to flow freely into the collection bag for one of two residents (Resident 79) reviewed under the urinary catheter care area. This failure had the potential to result in the backflow of urine into the resident's bladders, which can cause urinary tract infections (UTI- an infection in the bladder/urinary tract).[^] Findings: During a review of Resident 79's admission record, the admission record indicated, the facility initially admitted Resident 79 to the facility on 1/2/2023 and readmitted the resident on 11/28/2025 with diagnoses including unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by dead skin cells) pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) on his sacral (tail bone area) region and left heel, Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 79's Minimum Data Set (MDS - a resident assessment tool), dated 12/1/2025, the MDS indicated Resident 79's cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) was moderately impaired.[^] The Bladder and Bowel section of the MDS indicated Resident 79 was using an indwelling urinary catheter appliance. During a review of Resident 79's Care Plan (CP) dated 11/28/2025, the CP indicated Resident 79 has a Foley [specific brand of indwelling urinary catheter] catheter secondary to the presence of sacrococcyx (tail bone area) pressure injury. The goal of the CP is for Resident 79 to be free from signs and symptoms of UTI and will be free of related complications daily for 90 days. The interventions include to monitor and keep tubing patency and below the level of bladder. During a review of Resident 79's Physician Orders, the Physician Orders indicated an order dated 11/28/2025 for a Foley catheter for wound management. During a concurrent observation and interview on 12/29/2025 at 9:30 AM with Certified Nursing Assistant 1 (CNA 1), in Resident 79's room, Resident 79's urinary catheter tubing was observed to be looped preventing the free flow of urine through the tubing and into the collection bag. CNA 1 stated the tubing should not be looped and not have urine building up inside the tubing because this could cause Resident 79 to have an infection. During a concurrent observation and interview on 12/29/2025 at 9:35 AM with Licensed Vocational Nurse 1 (LVN 1) in Resident 79's room, Resident 79's urinary catheter tubing was observed to be looped preventing the free flow of urine through the tubing and into the collection bag. LVN 1 stated, the tubing should not be looped and have urine in the tubing since it can back up into Resident 79's bladder and cause a UTI. LVN 1 then moved the tubing to allow for the drainage of the urine into the drainage bag. During an interview on 12/29/2025 at 3:40 PM with Registered Nurse 1 (RN 1), RN 1 stated, indwelling urinary catheter tubing should never be looped because it could cause a back up urine into the resident and cause infection. RN 1 also stated, if this was ever to be observed, the tubing should be adjusted to allow for gravity to free flow the urine into the collection bag. During a review of the facility's Foley catheter insert for Medline SelectSilicone Foley Catheter Tray, dated 2019, the insert indicated, Directions for use . Hang drainage bag near the foot of the bed and position the tubing to ensure an unimpeded flow . Periodic observations of this system should be made to ensure urine is flowing freely. If standing column of urine is observed, check for correct positioning of bag and tubing. During a review of the facility's policy and procedure titled, Catheter-Associated Urinary Tract Infections, dated 8/28/2025, indicated, An indwelling catheter is attached to a drainage bag to allow for unrestricted flow of urine.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) center completed a pre and post-dialysis assessment (evaluation done after hemodialysis by the hemodialysis licensed nurses) by not ensuring the dialysis center recorded a resident's pre and post dialysis weights (the weight before and after fluid is removed during the dialysis treatment) on multiple days from 9/4/2025 to 12/18/2025 for one (Resident 34) of two residents in the facility who received dialysis treatments. This deficient practice had the potential for Resident 34 to have unidentified complications after dialysis treatment such as abnormal vital signs (pulse rate, temperature, respiration rate, and blood pressure). Findings: During a review of Resident 34's admission Record, the admission Record indicated the document indicated the resident was admitted to the facility on [DATE] and re-admitted on 7/27/2025 with diagnoses that included end stage renal failure (ESRD, irreversible kidney failure) and dependence on dialysis. During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 10/11/2025, the MDS indicated Resident 34 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 34 required setup assistance (helper sets up; resident completes activity) with eating and personal hygiene. The MDS indicated Resident 34 receives dialysis treatments. During a review of Resident 34's recent Physician's Orders, dated 12/05/2025, the orders indicated Resident 34 is to receive dialysis treatments Tuesdays, Thursdays, and Saturdays at a dialysis facility. During a review of Resident 34's Dialysis Communication Records, the Dialysis Communication Records indicated there were blank spaces for the post-dialysis weights on the following dates: 9/04/2025, 10/14/2025, 10/16/2025, 10/25/2025, 11/06/2025, 11/18/2025, 12/11/2025, and 12/18/2025. During a review of Resident 34's Dialysis Communication Records, the Dialysis Communication Records indicated there were blank spaces for the post-dialysis vital signs on the following dates: 10/14/2025, 10/16/2025, 10/25/2025, 12/11/2025 and 12/18/2025. During a review of Resident 34's Care Plan for Hemodialysis, initiated 7/27/2025, the care plan indicated a goal that the resident's blood pressure will remain below 160/90 (systolic blood pressure, the top number in the blood pressure reading, measuring the pressure in the arteries when the heart beats and pushes blood out and diastolic blood pressure, the bottom number in a blood pressure reading, representing the pressure in the arteries when the heart relaxes and fills with blood between beats) millimeters of mercury (mm Hg, a unit of measure for blood pressure). The care plan indicated an intervention to observe for elevated blood pressure and notify the physician promptly. During a concurrent interview and record review with the Minimum Data Set Nurse (MDSN) on 1/02/2025 at 10 a.m., the MDSN reviewed Resident 34's Dialysis Communication Records for the dates: 12/11/2025 and 12/18/2025. The MDSN confirmed on those dates there were no post-dialysis weights or vital signs recorded. The MDSN reviewed Resident 34's Nursing Progress Notes to see if any of the facility's licensed nurses called the dialysis center to obtain the missing weights and vital signs and confirmed the licensed nurses had not contacted the dialysis center. During a concurrent interview and record review with the Director of Nursing (DON) on 1/02/2025 at 10:19 a.m. reviewed Resident 34's Dialysis Communication Records for the dates: 9/04/2025, 10/14/2025, 10/16/2025, 10/25/2025, 11/06/2025, 11/18/2025, 12/11/2025, and 12/18/2025. The DON stated the process is for the facility licensed nurses to check the Dialysis Communication Record to ensure the dialysis center staff recorded the post dialysis weights and vital signs and if there is any missing entries, the licensed nurses are to call the dialysis center on the phone to obtain those missing entries. The DON reviewed Resident 34's Nursing Progress Notes for the above dates. The DON confirmed the Communication Records for the above dates indicated there were no post dialysis weights. The DON confirmed there (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were no post-dialysis vital signs for the following dates: 10/14/2025, 10/16/2025, 10/25/2025, 12/11/2025 and 12/18/2025. The DON stated it is important to have post-dialysis weights and vital signs to see if there was a drop in the vital signs and weights than what is normally expected. The DON stated Resident 34 could be at risk for hypotension (low blood pressure) which could result in dizziness and syncope. During a review of the facility's policy and procedure (P&P) titled, Dialysis Care, last reviewed 8/28/2025, the P&P indicated there should be documentation of a pre-dialysis and post-dialysis weights and vital signs for each dialysis treatment.		

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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 antibiotic stewardship (actions designed to use antibiotic [medications that fight bacterial infections] medications effectively while reducing the possibility of being prescribed an unnecessary medication) program by failing to conduct and complete an infection surveillance form before antibiotics were initiated for one of two sampled residents (Resident 15). This deficient practice had the potential for Resident 15 to develop antibiotic resistance (not effective to treat infection) from unnecessary or inappropriate antibiotic use for future infections. Findings: During a review of Resident 15's admission Record, the admission Record indicated the facility originally admitted the resident on 12/4/2025 with diagnoses including sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) and urinary tract infection (UTI- infection in the urinary system). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool) dated 12/10/2025, the MDS indicated Resident 15 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and had a maximal assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 15's physician order dated 12/23/2025, the physician order indicated an order for Macrobid 100 milligram (mg- unit of measurement) one capsule by mouth two times a day for UTI for one week. During a concurrent interview and record review on 12/31/2025 at 10:47 a.m., with the Infection Preventionist Nurse (IPN), reviewed Resident 15's medical record and facility's surveillance data collection form. Resident 15's medical record and facility's surveillance data collection form indicated missing antibiotic surveillance for Macrobid order. The IPN stated and validated the missing antibiotic surveillance for Resident 15's Macrobid order and added that it is important to do antibiotic surveillance for all antibiotic orders using the facility's surveillance data collection form and notification to the physician with proper documentation if criteria were not met. During an interview on 1/2/2025 at 11:01 a.m., with the Director of Nursing (DON), the DON stated that the facility should be monitoring all antibiotics' criteria for appropriate use and stated the importance of using the surveillance form and documentation when criteria was not met for the use of the antibiotic. During a review a review of facility's policy and procedure (P&P) titled, Infection Control-Antibiotic Stewardship, reviewed on 8/28/2025, the P&P indicated, Facility establishes antibiotic stewardship that promotes the appropriate use of antibiotic and a system of monitoring to improve resident outcomes and reduces antibiotic resistance.the goal is to ensure that an antibiotic is prescribed for the correct indication, dose and duration to treat a resident while attempting to reduce the development of antibiotic resistant organism.		

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide at least 80 square feet (sq. ft. - unit of measurement) per resident in multiple resident bedrooms for four of 38 resident rooms (Rooms 1, 3, 9, and 11). Rooms 1, 3, 9, and 11 all have two beds in each room. This deficient practice had the potential to result in inadequate useable living space for all the residents and inadequate working space for the health caregivers. Findings: During a review of the Request for Room Size Waiver letter dated 11/1/2025, submitted by the Administrator (ADM), the letter indicated the rooms (room [ROOM NUMBER], 3, 9, and 11) did not meet the 80 sq. ft. requirement per federal regulation. The letter indicated the residents' beds were in accordance with the special needs of the residents and will not adversely affect the residents' health and safety and do not impede the ability of the residents in that room to obtain their highest practicable well-being. During a review of the document titled, Client Accommodations Analysis dated 11/7/2025, submitted by the facility, the document indicated the following rooms with their corresponding measurements: Room # ~~~~~ No. # of beds ~ Total Square feet/total square feet per resident 1 ~~~~~ 2 ~~~~~ <table border="0"> <tr> <td>~~~~~ 146/ 73 3 ~~~~~</td> <td>~~~~~ 2 ~~~~~</td> </tr> <tr> <td>~~~~~ 155/ 77.5 9 ~~~~~</td> <td>~~~~~ 2 ~~~~~</td> </tr> <tr> <td>~~~~~ 143/ 71.5 11 ~~~~~</td> <td>~~~~~ 2 ~~~~~</td> </tr> <tr> <td>~~~~~ 151/ 75.5 ~~~~~</td> <td></td> </tr> </table> During the resident council (a group of nursing home residents who meet regularly to discuss their rights, quality of care, and quality of life) meeting on 12/29/2025 at 2:33 p.m., no concerns were brought up by the residents regarding the size of the rooms. During the general observation of the residents' rooms (1, 3, 9 and 11) on 12/29/2025, 12/30/2025, 12/31/2025, and 1/2/2026, rooms were not occupied by more than three residents; provided enough space for care, dignity, and privacy; ample room space for residents to move freely; and no concerns observed related to space or to the safe provisions of care to the residents residing in the rooms.			~~~~~ 146/ 73 3 ~~~~~	~~~~~ 2 ~~~~~	~~~~~ 155/ 77.5 9 ~~~~~	~~~~~ 2 ~~~~~	~~~~~ 143/ 71.5 11 ~~~~~	~~~~~ 2 ~~~~~	~~~~~ 151/ 75.5 ~~~~~	
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