STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056380	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure to provide the name of the medications and their indications (reasons for the use of the medications) prior to administration of seven medications, affecting one of six sampled residents (Resident 23) observed for medication administration. This deficient practice violated Resident 23 ' s rights to make decisions regarding their medication regimen, withhold treatment or seek alternatives, potentially resulting in psychosocial (relating to the interrelation of social factors and individual thought and behavior) harm. Findings: During a review of Resident 23 ' s admission Record, dated 6/3/2025, the admission Record indicated Resident 23 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including type two diabetes mellitus ([DM2- a disorder characterized by difficulty in controlling blood sugar level,) and hypertension (high blood pressure.) During a review of Resident 23 ' s Medication Administration Record ([MAR] - a record of medications administered to residents), dated 6/2025, the MAR indicated Resident 23 was prescribed the following medications: amlodipine 5 milligram ([mg] -a unit of measure of mass) two tablets to be given by mouth once a day for hypertension, at 9 a.m. ascorbic acid 500 mg one tablet to be given by mouth once a day for supplement, at 9 a.m. cholecalciferol 25 microgram ([mcg] – a unit of measure of mass) one tablet to be given by mouth once a day for supplement, at 9 a.m. docusate 100 mg one tablet to be given by mouth twice a day for bowel management, at 9 a.m. and 5 p.m. emplaglifozin 25 mg one tablet to be given by mouth once a day for DM2, at 9 a.m. multivitamin with minerals one tablet to be given by mouth once a day for supplement, at 9 a.m. lubiprostone 24 mcg one tablet to be given by mouth twice a day for bowel management, at 9 a.m. and 5 p. m. (continued on next page)

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/3/2025 at 10:02 a.m., Licensed Vocational Nurse (LVN) 3 was observed administering amlodipine (a medication used to treat high blood pressure,) docusate (a medication used for bowel [intestine] management,) lubiprostone (a medication used for bowel management,) cholecalciferol (a supplement for bone support,) multivitamin with minerals (a supplement for bone support,) ascorbic acid (a supplement for immune support,) and emplaglifozin (a medication used for DM2) tablets orally to Resident 23. Resident 23 was observed swallowing the amlodipine, docusate, lubiprostone, cholecalciferol, multivitamin with minerals, ascorbic acid and emplaglifozin tablets with a glass of water. LVN 3 was not observed informing Resident 23 the name of each medication and the indications during administration of the medications. During an interview on 6/3/2025 at 10:06 a.m., with LVN 3, LVN 3 stated during the medication administration that day (6/3/2025) at 10:02 a.m., LVN 3 administered amlodipine, docusate, lubiprostone, cholecalciferol, multivitamin with minerals, ascorbic acid and emplaglifozin tablets to Resident 23 and failed to inform Resident 23 the names of the medications and the indications prior to the resident swallowing each medication. LVN 3 stated that Resident 23 speaks and understands Spanish and LVN 3 was unable to speak in Spanish. LVN 3 stated usually LVN 3 requests a translator and that LVN 3 failed to request one that day (6/3/2025.) LVN 3 stated not having a translator placed Resident 23 at a disadvantage by not being understood and violating Resident 23 ' s rights. LVN 3 stated according to facility policy LVN 3 should have requested a translator and informed Resident 23 the name and indication of each medication administered that morning (6/3/2025), and by not doing so LVN 3 failed to give Resident 23 the right to be involved in their care and treatment and be able to make choices such as refusing a specific medication. During an interview on 6/3/2025 at 3:08 p.m., with the Director of Nursing (DON), the DON stated that LVN 3 failed to inform the name of the medications and the indications and side effects (unwanted, uncomfortable, or dangerous effects that a medication may have) prior to medication administration on 6/3/2025 to Resident 23. The DON stated that it was important to follow this process to ensure residents have the right to be informed about their care and make decisions about their treatments. The DON stated not providing this information during medication administrations restricts the residents from this right. During a review of the facility ' s policy and procedures (P&P), titled Resident Rights – Quality of Life, last reviewed 4/30/2025, the P&P indicated, To ensure that each resident receives the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well-being, consistent with the resident ' s comprehensive assessment and plan of care. During a review of the facility ' s P&P titled Resident Rights – Accommodation of Needs, last reviewed 4/30/2025, the P&P indicated, To ensure that the Facility provides an environment and services that meet residents ' individual needs. VI. Facility Staff interacts with the residents in a way that accommodates the physical or sensory limitations of the residents, promotes communication . During a review of the facility ' s P&P titled Administration Procedures for All Medications, last reviewed 4/30/2025, the P&P indicated, When applicable, explain to resident the type of medication being administered.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of the resident for one of one sampled resident (Resident 87) reviewed under accommodation. The deficient practice had the potential for Resident 87 unable to summon health care worker for help as needed. Findings: During a review of Resident 87 ' s admission Record, the admission Record indicated the facility admitted the resident on 9/12/2023, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (an open sore on the foot that does not heal properly and can lead to complications if left untreated), and obesity. During a review of Resident 87 ' s History and Physical (H&P), dated 10/16/2024, the H&P indicated the resident had physical deconditioning (the loss of strength, endurance, and physical fitness due to prolonged inactivity) due to limitation with ambulation due to left foot prior infection and the resident ' s bilateral feet were developing extension contractures (a condition where a joint is stuck or limited in its ability to bend). During a review of Resident 87 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/22/2025, the MDS indicated the resident had the ability to make self understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated Resident 87 required moderate to setup assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 87 ' s Fall Risk Evaluation, dated 3/22/2025, the Fall Risk Evaluation indicated the resident was not at risk for potential falls. During a review of Resident 87 ' s Care Plan (CP) Report titled, The resident is at risk for falls related to left foot diabetic ulcer wound, last revised on 9/29/2024, the CP indicated an intervention to ensure the resident ' s call light is within reach and encourage the resident to use it for assistance as needed. The CP indicated Resident 87 needs prompt response to all requests for assistance. During a concurrent observation and interview on 6/3/2025, at 11:15 a.m., with Licensed Vocational Nurse (LVN) 2, inside Resident 87 ' s room, observed Resident 87 ' s call light was on the floor at the right side of the bed. LVN 2 stated Resident 87 ' s call light should be always within Resident 87 ' s reach so the resident can call for help when needed. LVN 2 stated it was everyone ' s responsibility in the facility to ensure the call lights are within reach of the residents. LVN 2 stated the failure of the staff on not keeping the call light within the reach of Resident 87 can predispose the resident to falls with injuries such as fracture (a break in a bone) and lacerations (a skin wound) due to falls. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2025, at 9:43 a.m., with the Director of Staff Development (DSD), the DSD stated the call light of Resident 87 should be within reach so the resident can call for help when needed. The DSD stated the resident can fall while reaching for the call light that is on the floor which could cause falls with injury. The DSD stated she had educated all staff to ensure the call light was within reach at all times for all residents. During an interview on 6/6/2025, at 11:14 a.m., with the Assistant Director of Nursing (ADON), the ADON stated it was the responsibility of all staff to ensure the call light was within reach for Resident 87. The ADON stated the staff should be doing environmental checks every time they go to the residents ' bedside and that is including the call lights should always be within reach. The ADON stated the failure of the staff to keep Resident 87 ' s call light within reach can result to Resident 87 not able to call for help when needed and could fall while reaching for the call light on the floor and sustain injuries such as fall with fracture. During a review of the facility's recent policy and procedure (P&P) titled Communication- Call System, last reviewed on 4/30/2025, the P&P indicated the Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities. II. Call cords will be placed within the resident's reach in the resident's room. A. When the resident is out of bed, the call cord will be clipped to the bedspread in such a way as to be available to a wheelchair bound resident.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** c. During a review of Resident 31 ' s AR, the AR indicated the facility originally admitted the resident on 5/18/2020 and readmitted in the facility on 4/30/2025 with diagnoses including cerebral infarction (stroke, loss of blood flow to a part of the brain), dementia (a progressive state of decline in mental abilities), and type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 31 ' s History and Physical (H&P) dated 5/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 31s MDS, dated [DATE], the MDS indicated Resident 31 was able to understand others and make her needs known but with severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicate Resident 31 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 31 had an impairment on both lower extremities. During a review of Resident 31 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order dated 5/6/2025 floor mat on one side and low bed every shift. During a review of Resident 31 ' s fall risk evaluations dated 2/5/2025, 4/30/2025, and 5/6/2025, the fall risk evaluations indicated Resident 31 was a risk for falls. During an observation on 6/3/20205 at 9:13 a.m., inside Resident 31 ' s room, observed Resident 31 lying in bed asleep with floor mat on the right side. Observed Resident 31 ' s floor mat on the right side with a linear tear on the lower part with the foam padding exposed underneath. During a concurrent observation and interview on 6/3/2025 at 2:30 p.m. inside Resident 31 ' s room with the Director of Staff Development (DSD), the DSD stated Resident 31 ' s had a linear tear on the lower part of the mat with the foam padding underneath exposed. The DSD stated floor mats should be free from tears or rips as the facility was not providing a homelike environment for the residents. The DSD stated the staff should notify the maintenance department so the floor mat can be changed. The DSD stated Resident 31 ' s floor mat should have been free from tears as the facility was not providing a homelike environment for the resident which can affect their quality of life. During an interview on 6/6/2025 at 11:54 a.m. with the DON, the DON stated the staff are responsible in making sure the floor mats were free from tears or any equipment in the room in disrepair as the facility was not providing a homelike environment. The DON stated if the staff notice any equipment in a resident room was not in good working condition such as tears on the floor mat, the maintenance department should be notified immediately to change the floor mat. The DON stated residents have the right to have a safe and clean environment. The DON stated the staff should have notified the maintenance department to change Resident 31 ' s floor mat. The DON if Resident 31 ' s floor mat was in disrepair or had tears, the facility was not providing a clean, and homelike environment to the resident which may affect her quality of life. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. During a review of Resident 85 ' s AR, the AR indicated the facility originally admitted the resident on 11/9/2023 and readmitted in the facility on 5/5/2025 with diagnoses including cognitive communication deficit (a condition characterized by difficulty with attention, memory, reasoning, planning, organization, and/or language skills), schizophrenia (a mental illness that is characterized by disturbances in thought), and generalized muscle weakness. During a review of Resident 85 ' s H&P dated 7/22/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 85 ' s MDS, dated [DATE], the MDS indicated Resident 85 was sometimes able to understand others and make his needs known but with moderately impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicate Resident 85 required setup or clean-up assistance with eating; partial/moderate assistance with walking, lying to sitting on edge of bed, and sit to stand; total assistance from staff with bathing; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 85 had an impairment on both lower extremities. During a review of Resident 85 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order dated 5/12/2025 for bilateral floor mats for fall and safety precaution every shift. During a review of Resident 85 ' s fall risk evaluations dated 3/13/2025, 5/5/2025, and 5/9/2025, the fall risk evaluations indicated Resident 85 was a risk for falls. During an observation on 6/3/20205 at 9:32 a.m., inside Resident 85 ' s room, observed Resident 85 lying in bed asleep with floor mats on both sides of the bed. Observed Resident 85 ' s left floor mat with multiple scratches on the top. During a concurrent observation and interview on 6/3/2025 at 2:35 p.m. inside Resident 85 ' s room with the DSD, the DSD stated Resident 85 ' s left floor mat had multiple scratches on the top. The DSD stated floor mats should be free from tears or scratches as the facility was not providing a homelike environment for the residents. The DSD stated the staff should notify the maintenance department so the floor mat can be changed. The DSD stated Resident 85 ' s floor mat should have been free from multiple scratches as the facility was not providing a homelike environment for the resident which can affect their quality of life. During an interview on 6/6/2025 at 11:54 a.m. with the DON, the DON stated the staff are responsible in making sure the floor mats were free from tears or any equipment in the room in disrepair as the facility was not providing a homelike environment. The DON stated if the staff notice any equipment in a resident room was not in good working condition such as tears and/or scratches on the floor mat, the maintenance department should be notified immediately to change the floor mat. The DON stated residents have the right to have a safe and clean environment. The DON stated the staff should have notified the maintenance department to change Resident 85 ' s floor mat. The DON if Resident 85 ' s floor mat had multiple scratches, the facility was not providing a clean, and homelike environment to the resident which may affect his quality of life. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility P&P titled, Maintenance Service, last reviewed 4/30/2025, the P&P indicated the purpose is to protect the health and safety of residents, visitors, and Facility Staff. The Maintenance Department maintains all areas of the building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the Maintenance Department may include, but are not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. During a review of the facility P&P titled, Resident Rooms and Environment, last reviewed 4/30/2025, the P&P indicated the purpose is to provide residents with a safe, clean, comfortable and homelike environment. The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to cleanliness and order. During a review of the facility provided Bed Frame (BF) 1 manual, dated 4/1/2018, the manual indicated any cords used on or with the bed must be routed and secured properly to ensure they do not become severed during normal operation of the bed. Service and repair must only be performed by authorized service personnel. Do not operate the bed if any electrical component such as the power cord, electrical outlet, connections, motor/actuator or mechanical component has been damaged in any way. Failure to properly maintain the bed may increase risk to residents and staff. During a review of the facility P&P titled, Resident Safety, last reviewed 4/30/2025, the P&P indicated the purpose is to provide a safe and hazard free environment. Observe the safety and wellbeing of the Residents, a Resident check will be made at least every two hours around the clock by nursing service personnel. Any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. Based on observation, interview, and record review, the facility failed to provide a safe, homelike environment reviewed under the Environment task, by failing to: 1. Ensure the resident ' s bed frame control was in good repair when the control box cord had frayed and exposed wires for one of four sampled residents (Resident 25). 2.Ensure the resident ' s wall baseboard was in good repair when the baseboard was broken and exposing sharp nails for one of four sampled residents (Resident 18). 3. Ensure the residents floor mats did not have a crack and were in disrepair for two of three sampled residents (Residents 31 and 85). These deficient practices had the potential to negatively affect Residents 25, 18, 31, and 85 ' s psychosocial wellbeing resulting in the residents feeling uncomfortable in their living space. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Cross reference F908 and F689. Findings: a. During a review of Resident 25 ' s admission Record (AR), the AR indicated the facility admitted the resident on 9/11/2021 with diagnoses that included epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]), cognitive communication deficit (trouble communicating because of difficulties with thinking processes, like attention, memory, or reasoning), and mood disorder (a mental health condition that primarily affects emotional state). During a review of Resident 25 ' s Minimum Data Set (MDS – resident assessment tool), dated 3/13/2025, the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated that Resident 25 required substantial/maximal assistance from staff for bathing, dressing, personal and oral hygiene; and the resident was dependent on staff for mobility. During a review of Resident 25 ' s Care Plan (CP) titled, Fall Prevention, initiated 11/23/2021 and last revised 9/30/2025, the CP indicated an intervention to provide the resident with a safe environment. During a concurrent observation and interview on 6/3/2025 at 10:25 a.m., Resident 25 lay awake in bed while Certified Nursing Assistant (CNA) 2 was in the resident ' s room. CNA 2 exited the room. Resident 25 stated there were exposed wires on the bed control cord. Observed the bed control cord partially wrapped with black tape with exposed wires visible. Resident 25 stated a man came and placed the tape on the bed control cord a while ago, but there remained exposed wires that were not safe. Resident 25 stated Resident 25 needed a new bed control and not just one that had been taped. During an observation on 6/4/2025 at 10:10 am, observed Resident 25 lying in bed awake. Observed the bed control cord with exposed frayed wires, no black tape was present. During a concurrent observation and interview on 6/4/2025 at 10:15 a.m., CNA 2 entered Resident 25 ' s room and stated Resident 25 ' s bed control cord was previously repaired with tape to cover the exposed wires, CNA 2 stated on 6/4/2025 at 7:30 a.m., CNA 2 found Resident 25 ' s bed control cord with exposed and frayed wires and no black tape. CNA 2 stated CNA 2 did not report the exposed and frayed wires because CNA 2 was busy. CNA 2 stated CNA 2 should have reported the bed control cord to maintenance right away because it was not safe for Resident 25 to have the broken bed control cord. During a concurrent observation and interview on 6/4/2025 at 10:30 a.m. with the Maintenance Assistant (MA), the MA entered Resident 25 ' s room. The MA stated it was not ok for the bed control to have exposed wires because it could be dangerous for the resident. The MA stated exposed and frayed wires on the cord should be reported right away by the staff. The MA stated the MA had previously repaired Resident 25 ' s bed control cord by placing black tape over the exposed wires, but the MA was not aware of any other issues with Resident 25 ' s cord. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025 at 2:29 p.m. with the Maintenance Director (MD), the MD stated it was not correct for the MA to repair Resident 25 ' s bed control cord by placing electrical tape over the exposed wires. The MD stated the MA should have followed up and replaced Resident 25 ' s bed if the MA could not locate a replacement bed control, but the MA did not follow up. The MD stated it was not a homelike environment for Resident 25 to have exposed and frayed wires or black tape on the cord of the bed control. During a concurrent interview and record review on 5/9/2025 at 9 a.m., the Director of Nursing (DON) reviewed the facility policy and procedures (P&P) regarding homelike environment and resident safety and the manual for Bed Frame (BF) 1. The DON stated any equipment or maintenance issues need to be reported immediately by staff to ensure the residents have a safe, homelike environment with everything working properly. The DON stated it is the facility policy that the maintenance department follows the equipment manuals to keep a resident ' s environment safe and homelike. The DON stated a homelike environment includes safety because everybody wants to feel safe in their house. The DON stated when a resident does not feel safe it may cause feelings of distress or anxiousness that can potentially affect the resident ' s participation in their activities of daily living. The DON stated when a resident ' s participation is affected it may cause a decline in the resident. The DON stated the facility P&P, and the BF 1 manual was not followed when Resident 25 had exposed and frayed wires on the bed control cord. b. During a review of Resident 18 ' s AR, the AR indicated the facility admitted the resident on 1/7/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body) following cerebral infarction (CVA-stroke, loss of blood flow to a part of the brain), depression (persistent feelings of sadness and loss of interest that can interfere with daily living), muscle weakness, and history of fall. During a review of Resident 18 ' s MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated Resident 18 required substantial/maximal assistance from staff for personal hygiene and mobility; and is dependent on staff for bathing, dressing, toileting. During a review of Resident 18 ' s CP titled, Fall Prevention initiated 1/18/2025, the CP indicated an intervention to provide the resident with a safe environment. During a concurrent observation and interview on 6/3/2025 at 9:15 a.m., Resident 18 lay awake in bed. Observed the wall at the head of the resident ' s bed with a broken baseboard detached from the wall and two exposed metal nails sticking out. During a concurrent observation and interview on 6/4/2025 at 2:21 p.m., with CNA 2, CNA 2 stated CNA 2 was aware that Resident 18 ' s baseboard was broken, but CNA 2 did not report the broken baseboard to the maintenance department because CNA 2 was busy. CNA 2 stated there were nails sticking out at the broken baseboard and CNA 2 was not sure how long the baseboard had been broken. CNA 2 stated CNA 2 would not like to have a broken baseboard with nails sticking out at CNA 2 ' s home because it was not safe or a nice appearance. CNA 2 stated Resident 18 ' s broken baseboard was not a homelike environment and could potentially result in affecting Resident 18 ' s mental health. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/4/2025 at 2:29 p.m. with the MD, the MD stated the MD was not aware Resident 18 ' s baseboard was broken with nails sticking out. The MD stated staff should have immediately reported the broken baseboard and nails because it was a safety issue, and the nails could potentially harm the resident. The MD stated Resident 18 ' s broken baseboard was not a safe environment. During a concurrent interview and record review on 5/9/2025 at 9 a.m., the DON reviewed the facility P&P regarding homelike environment and resident safety. The DON stated any equipment or maintenance issues need to be reported immediately by staff to ensure the residents have a safe, homelike environment. The DON stated a homelike environment includes safety because everybody wants to feel safe in their house. The DON stated when a resident does not feel safe it may cause feelings of distress or anxiousness that can potentially affect the resident ' s participation in their activities of daily living. The DON stated when a resident ' s participation is affected it may cause a decline in the resident. The DON stated the facility P&P was not followed when Resident 18 had a broken baseboard with nails sticking out and there was a potential for injury to the resident resulting in a tetanus infection (a serious and potentially fatal disease caused by a bacterial toxin contracted through wounds).

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	056380	A. Building B. Wing	06/06/2025

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident ' s body that he or she cannot easily remove that restricts freedom of movement or normal access to one ' s body) for four of six sampled residents (Residents 31, 59, 65, and 110) reviewed for physical restraints care area by: 1. Failing to ensure Residents 31 ' s and 59 ' s pillows were not tucked tightly under the fitted sheet. 2. Failing to obtain an order, informed consent, complete a physical restraint assessment, and develop and implement a care plan for the use of bolsters (a mattress designed with raised edges to help prevent patient from falling out of bed, especially those at risk of falls) on the low air loss mattress (LALM - a mattress that helps prevent and treat pressure wounds by circulating air and relieving pressure on the body) for Resident 65. 3. Failing to ensure Resident 110 ' s restraint bed placed against the wall had a physician ' s order, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) from the resident and/or representative, and physical restraint assessment for its safe use. These deficient practices had the potential to result in the restriction of Residents 31, 59, 65, and 110 ' s freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: a. During a review of Resident 31 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 5/18/2020 and readmitted in the facility on 4/30/2025 with diagnoses including cerebral infarction (stroke, loss of blood flow to a part of the brain), dementia (a progressive state of decline in mental abilities), and type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 31 ' s History and Physical (H&P), dated 5/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 31s MDS, dated [DATE], the MDS indicated Resident 31 was able to understand others and make her needs known but with severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicate Resident 31 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 31 had an impairment on both lower extremities. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 31 ' s Order Summary Report, the Order Summary Report did not indicate a physician ' s order for the use of pillows tucked under the fitted sheet. During a review of Resident 31 ' s fall risk evaluations dated 2/5/2025, 4/30/2025, and 5/6/2025, the fall risk evaluations indicated Resident 31 was a risk for falls. During a review of Resident 31 ' s care plan (CP) on risk for falls initiated on 1/1/2024 and last revised on 5/14/2025, the CP did not indicate an intervention for the use of pillows tucked under the fitted sheet. During an observation on 6/3/20205 at 9:13 a.m., inside Resident 31 ' s room, observed Resident 31 lying in bed asleep with pillows tucked under the fitted sheet. During a concurrent observation and interview on 6/3/2025 at 3:10 p.m. with the Director of Staff Development (DSD), inside Resident 31 ' s room, the DSD stated Resident 31 had pillows tucked under the fitted sheet on both sides. The DSD stated the staff are not supposed to use the pillow tucked under the fitted as it was preventing the resident ' s freedom of movement and can be considered a restraint. During an interview on 6/6/2025 at 9:30 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated Resident 31 is a high risk for falls and has the tendency to move towards the edge of the bed. CNA 9 stated she placed the pillows tucked under the fitted sheet on both sides as it was easier for her due to the pillows kept on falling on the ground every time the resident moved. CNA 9 stated she was made aware that staff are not supposed to put pillows under the fitted sheet as it prevents the residents from moving freely and can be considered a restraint. CNA 9 stated she should not have placed the pillows and tuck it under the fitted sheet instead of placing it on the top as it prevents Resident 31 to move freely and considered a restraint. During an interview on 6/6/2025 at 12:06 p.m. with the Director of Nursing (DON), the DON stated she was made aware that the pillows were tucked under Resident 31 ' s fitted sheet by the DSD and the Assistant Director of Nursing (ADON). The DON stated staff are not supposed to place the pillows under the fitted sheet as it can be considered a restraint as the residents are unable to remove it by themselves and move freely. The DON stated the pillows can be placed on top of the fitted sheet. The DON stated CNA 9 should have not tucked the pillows under Resident 31 ' s fitted sheet as CNA 9 used it for her convenience and can be considered a restraint. The DON stated a physical restraint assessment, physician ' s order, informed consent is not necessary as the staff are not supposed to place the pillows under the fitted sheet. b. During a review of Resident 59 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 12/11/2024 and readmitted in the facility on 5/27/2025 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), DM 2, and generalized muscle weakness. During a review of Resident 59 ' s H&P dated 12/11/2024, the H&P indicated the resident did not have the capacity to make healthcare decisions but able to decide for ADLs, and make her needs known. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59 ' s MDS, dated [DATE], the MDS indicated Resident 59 was able to understand others and make her needs known but with severely impaired cognition. The MDS further indicated Resident 59 required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene; substantial/maximal assistance with bathing and lower body dressing; partial/moderate assistance from staff with all ADLs. During a review of Resident 59 ' s Order Summary Report, the Order Summary Report did not indicate a physician ' s order for the use of pillows tucked under the fitted sheet. During a review of Resident 59 ' s fall risk evaluations dated 12/11/2024, 1/18/2025, and 5/27/2025, the fall risk evaluations indicated Resident 59 was a risk for falls. During a review of Resident 59 ' s care plan (CP) on risk for falls initiated on 12/12/2024, the CP indicated to provide a safe environment so Resident 59 will be free from falls for three months. During a concurrent observation and interview on 6/3/3035 at 9:23 a.m. inside Resident 59 ' s room with CNA 3, CNA 3 stated Resident 59 had pillows tucked under the fitted sheet on the right side as the resident had the tendency to move towards the right side of the body. CNA 3 stated Resident 59 was a high risk for falls due to weakness and being unstable. During a concurrent observation and interview on 6/3/2025 at 3:10 p.m. with the DSD, inside Resident 59 ' s room, the DSD stated Resident 59 had pillows tucked under the fitted sheet on the right side. The DSD stated the staff are not supposed to use the pillow tucked under the fitted as it was preventing the resident ' s freedom of movement and can be considered a restraint. During a follow up interview on 6/6/2025 at 7:38 a.m. with CNA 3, CNA 3 stated Resident 59 is a high risk for falls and has the tendency to move towards the edge of the bed on the right side. CNA 3 stated she placed the pillows tucked under the fitted sheet on both sides as it was easier for her due to the pillows kept on falling on the ground every time the resident moved. CNA 3 stated she was made aware that staff are not supposed to put pillows under the fitted sheet as it prevents the residents from moving freely and is considered a restraint. CNA 3 stated she should not have placed the pillows and tuck it under the fitted sheet instead of placing it on the top as it prevents Resident 59 to move freely and considered a restraint. During an interview on 6/6/2025 at 12:06 p.m. with the DON, the DON stated she was made aware that the pillows were tucked under Resident 59 ' s fitted sheet by the DSD and the ADON. The DON stated staff are not supposed to place the pillows under the fitted sheet as it can be considered a restraint as the residents are unable to remove it by themselves and move freely. The DON stated the pillows can be placed on top of the fitted sheet. The DON stated CNA 3 should have not tucked the pillows under Resident 59 ' s fitted sheet as CNA 3 used it for her convenience and can be considered a restraint. The DON stated a physical restraint assessment, physician ' s order, informed consent is not necessary as the staff are not supposed to place the pillows under the fitted sheet. c. During a review of Resident 65 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 5/9/2022 and readmitted in the facility on 6/28/2022 with diagnoses including muscle wasting atrophy, dementia, and generalized muscle weakness. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 65 ' s H&P dated 5/30/2025, the H&P did not indicate Resident 65 ' s decision making capacity. During a review of Resident 65 ' s MDS, dated [DATE], the MDS indicated Resident 65 was able to understand others and make his needs known but with severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 65 required total assistance from staff with all ADLs. During a review of Resident 65 ' s Order Summary Report dated 6/12/2025, the Order Summary Report did not indicate a physician ' s order for the use of LALM with built in bilateral upper and lower bolsters. During a review of Resident 65 ' s fall risk evaluations dated 12/25/2024 and 5/28/2025, the fall risk evaluations indicated Resident 65 was a risk for falls. During a review of Resident 65 ' s care plan (CP) titled, Fall Prevention and Management, potential for injury related to fall risk initiated on 6/28/2025 and last revised on 6/3/2025, the CP indicated the resident needs a safe environment with even floors free from spills and/or clutter to keep Resident 65 free from falls. During a concurrent observation and interview on 6/3/3035 at 3:05 p.m. inside Resident 65 ' s room with Treatment Nurse (TN) 1, TN 1 stated Resident 65 ' s LALM had built in bilateral upper and lower bolsters used as a support for Resident 65 ' s turning and repositioning. TN 1 stated she is not sure if there was a physician ' s order for the use of the bolsters. During a concurrent interview and record review on 6/5/2025 at 9:44 a.m., reviewed Resident 65 ' s physical restraint assessment, physician ' s order, informed consent, and CP, and the facility ' s policy and (P&P) titled, Restraint with MDS Coordinator (MDSC) 2. MDSC 2 stated there was no physician ' s order, informed consent, and care plan for the use of the bolsters until identified on 6/3/2025. MDSC 2 stated there was no physical restraint assessment initiated as the facility utilizes the bolsters for trunk control, hence, not considered as a restraint. MDSC 2 stated the P&P indicated, physical restraints restrict freedom of movement and/or access to a part of the resident ' s body for safety or postural positioning. MDSC 2 stated if a physical restraint is required for a resident, the licensed nurse is supposed to complete a physical restraint, obtain physician ' s order, obtain informed consent to give the resident/resident representative chance to decline or agree with the plan, and develop and implement a care plan so everybody would be aware of the plan of care. MDSC 2 stated the physical restraint assessment should have been completed when the bolsters were used, obtain a physician ' s order, informed consent, and develop and implement a care plan for the use of the bolsters. MDSC 2 stated Resident 65 ' s bolsters can still be considered a restraint even if it was used for trunk control or postural positioning as it was preventing Resident 65 to move freely. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a n interview on 6/6/2025 at 12:10 p.m. with the DON, the DON stated if a resident needed a restraint, a physical restraint should be completed to ensure the use of the restraint is appropriate, obtain a physician ' s order, obtain informed consent to give the resident/resident representative opportunity to agree to the plan or decline, and develop and implement a care plan so that all staff involved in the resident ' s care will be aware of the plan of care. The DON stated there was no physical restraint assessment, physician ' s order, informed consent, and care plan for the use of bolsters on Resident 65. The DON stated the facility should have completed a physical restraint assessment for the use of bilateral upper and lower bolsters on Resident 65 to ensure the use of the restraint was appropriate and least restrictive interventions have been attempted, physician ' s order should have been obtained, obtain informed consent from the resident/representative, and develop and implement a care plan as the application of restraint was not honoring the resident ' s right to be free from the use of restraints. d. During a review of Resident 110 ' s admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (a condition where you have weakness on one side of your body, often affecting the arm, leg, and sometimes the face) following cerebral infarction (a stroke caused by a blockage in the blood vessels that supply blood to the brain), and muscle weakness. During a review of Resident 110 ' s H&P, dated 4/4/2025, the H&P indicated the resident was able to understand and make medical decisions. During a review of Resident 110 ' s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. The MDS indicated the resident had bilateral lower extremity impairment and uses walker and wheelchair to ambulate. The MDS indicated the resident was dependent to needing supervision on mobility and ADL. During a review of Resident 110 ' s Order Summary Report, dated 6/5/2025, the Order Summary Report did not indicate an order for restraint bed placed against the wall. During a review of Resident 110 ' s Fall Risk Evaluation, dated 4/3/2025, the Fall Risk Evaluation indicated the resident was high risk for potential falls. During a concurrent observation and interview on 6/5/2025, at 8:13 a.m., with CNA 5, inside Resident 110 ' s room, observed Resident 110 ' s bed was placed against the wall at the left side of the bed. CNA 5 stated the resident had the bed against the wall to prevent resident falls. During a concurrent interview and record review on 6/5/2025, at 9:06 a.m., with the DSD, reviewed Resident 110 ' s Order Summary Report, Informed Consent, Restraint Assessment, and Care Plan. The DSD stated there was no order for restraint bed placed against the wall, no informed consent, no restraint assessment, and no care plan on its use. The DSD stated it was important to have a physician ' s order, restraint assessment, and care plan to ensure its safe use and to prevent bed entrapment. The DSD stated an informed consent is needed prior to the application of the bed placed against the wall to honor the right of the resident to informed consent and to give the resident or representative time to agree to disagree to proposed medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/2025, at 11:14 a.m., with the ADON, the ADON stated the licensed staff should have obtained a physician ' s order, informed consent, restraint assessment, and a care plan on the use of bed placed against the wall on Resident 110 prior to its use to ensure it is safe to use them. The ADON stated the care plan serves as a communication to the interdisciplinary team (IDT, a group of individuals from different fields or disciplines who collaborate to achieve a common goal) of interventions agreed upon by the IDT to standardize the care provided to the resident. The ADON stated they needed an informed consent from the resident or representative to honor their right to agree or disagree to the proposed treatment. During a review of the facility ' s recent policy and procedure (P&P) titled, Restraint, last reviewed on 4/30/2025, the P&P indicated before any type of restraint is used, the licensed nurse will verify that the prescribing healthcare practitioner obtained informed consent from the resident/resident representative and has been documented in the resident's medical record. The P&P further indicated: Reasons why a restraint cannot be used: When the restraint is not necessary to treat the resident ' s medical symptoms. For the purpose of discipline. Staff convenience. Unless otherwise specified by the Attending Physician ' s order, alternative methods of behavioral management must be attempted before a physical restraint is used and documented in the resident ' s medical record. Assessment a. Once decision has been reached to use a restraint, a Licensed Nurse will complete the Physical Restraint-Assessment. b. The Physical Restraint Assessment will be included in the resident's medical record. Restraint Order from Attending Physician a. The order must be specific to the individual resident and must include the following information: i. The presence of a medical symptom that requires the use of restraint; ii. The type of restraint to be used; iii. When the restraint is to be used; and iv. The period of time the restraint is to be used. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Physical restraints restrict freedom of movement and/or access to a part of the resident ' s body for safety or postural positioning. - Alternative method of behavioral management must be attempted before a physical restraint is used and documented in the resident ' s medical record. - When a physical restraint is used, the licensed nurse will develop a plan of care to include systematic and gradual approaches for minimizing or eliminating the concerning behavior and restraint use. During a review of the facility's recent P&P titled Informed Consent, last reviewed on 4/30/2025, the P&P indicated the licensed nurse will confirm that the Healthcare Practitioner obtained informed consent and will document the verification in the Resident's medical record, before administering the first dose or first increased dose of psychoactive medications, applying physical restraints or medical devices. Documenting of the verification of informed consent may be done by: i. Contacting the Resident or decision-maker (including Surrogate IDT) to verify that the Healthcare Practitioner obtained informed consent for the order. During a review of the facility's recent P&P titled Comprehensive Person-Centered Care Planning, last reviewed on 4/30/2025, the P&P indicated within 7 days from the completion of the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan.

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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. Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of six sampled residents (Resident 110) reviewed for physical restraints (the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body) by failing to develop and implement a care plan on the use of restraint bed placed against the wall. This deficient practice had a potential for delays in the delivery of necessary care and services and adverse effects (an undesired effect of a drug or other type of treatment, such as surgery) to Resident 110. Findings: During a review of Resident 110 ' s admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial muscular weakness or partial paralysis affecting only one side of the body) following cerebral infarction (the death of brain tissue caused by a sudden reduction or blockage of blood flow to the brain) and muscle weakness. During a review of Resident 110 ' s History and Physical (H&P), dated 4/4/2025, the H&P indicated the resident had the ability to understand and make medical decisions. During a review of Resident 110 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2025, the MDS indicated the resident had the ability to make self understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated Resident 110 had both lower extremity impairment and was using walker and wheelchair to ambulate. The MDS indicated Resident 110 was dependent to needing supervision on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 110 ' s Order Summary Report, dated 6/5/2025, the Order Summary Report did not indicate an order for restraint bed placed against the wall. During a review of Resident 110 ' s Fall Risk Evaluation, dated 4/3/2025, the Fall Risk Evaluation indicated the resident was high risk for potential falls. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation, interview, and record review on 6/5/2025, at 9:06 a.m., with the Director of Staff Development (DSD), inside Resident 110 ' s room, observed Resident ' s bed was placed against the wall on the left side of the resident ' s bed. The DSD stated placing the bed against the wall is a form of restraint as they are limiting the freedom of the resident to get out on both sides of the bed. The DSD stated they placed the resident ' s bed against the wall as a fall intervention. The DSD stated there was no care plan developed and implemented on the use of restraint bed placed against the wall on the resident ' s electronic medical record. The DSD stated the failure of the facility to develop and implement a care plan on the use of bed placed against the wall predisposed the resident to bed entrapment (patient being caught, trapped or entangled in the spaces in or about the bed rail, mattress or hospital bed frame) and substandard care due to miscommunication of agreed upon interventions. During an interview on 6/6/2025, at 11:14 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should have developed and implemented a care plan on the use of restraint bed placed against the wall to ensure the agreed upon care planned interventions were followed and communicated to the interdisciplinary team (IDT, a group of individuals from different fields or disciplines who collaborate to achieve a common goal) to provide standardized care to residents. During a review of the facility's recent policy and procedure (P&P) titled Comprehensive Person-Centered Care Planning, last reviewed on 4/30/2025, the P&P indicated within 7 days from the completion of the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility ' s licensed nursing staff failed to provide care in accordance with professional standards to two of five sampled residents (Residents 110 and 6) reviewed for unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites on multiple days. This deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: 1. During a review of Resident 110 ' s admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and mild protein-calorie malnutrition (a condition where a person, especially children, does not consume enough protein and calories to meet their body's needs). During a review of Resident 110 ' s History and Physical (H&P), dated 4/4/2025, the H&P indicated the resident was able to understand and make medical decisions. During a review of Resident 110 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/10/2025, the MDS indicated Resident 110 had the ability to make self understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated Resident 110 was on a high-risk drug class hypoglycemic medication (drugs that are prescribed to help lower blood sugar levels, specifically to manage and treat conditions like diabetes). During a review of Resident 110 ' s Order Summary Report, dated 5/24/2025, the Order Summary Report indicated an order of Novolog 100 unit/ml (means how many units of insulin are contained within each milliliter of liquid) Flexpen. Inject as per sliding scale (a method of managing blood sugar levels in people with diabetes where the amount of insulin given is adjusted based on the current blood sugar reading): if 70 - 150 = 0 unit; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units; 401+ = 12 units, subcutaneously before meals and at bedtime for diabetes mellitus (DM) type 2 blood sugar (BS) below 70 initiate hypoglycemia protocol (a set of guidelines or steps to follow when someone's blood sugar drops too low). Call MD if BS below 70 or above 400. Rotate injection sites. During a review of Resident 110 ' s Location of Insulin Administration Report from 4/2025 to 6/2025, indicated Novolog 100 unit/ml Flexpen was administered on: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/8/2025 at 12:12 p.m. on the Abdomen-Left Lower Quadrant (LLQ) - 4/9/2025 at 12:16 p.m. on the Abdomen-LLQ - 4/10/2025 at 4:48 p.m. on the Arm-right - 4/11/2025 at 5:39 p.m. on the Arm-right - 4/12/2025 at 4:58 p.m. on the Arm-right - 4/15/2025 at 8:55 p.m. on the Arm-right - 4/17/2025 at 5:43 p.m. on the Arm-right - 5/8/2025 at 8:36 p.m. on the Arm-left - 5/9/2025 at 8:20 p.m. on the Arm-left - 5/10/2025 at 5:27 p.m. on the Arm-right - 5/11/2025 at 7:48 p.m. on the Arm-right - 5/30/2025 at 5:02 p.m. on the Arm-right - 5/31/2025 at 4:43 p.m. on the Arm-right During a concurrent interview and record review on 6/5/2025, at 9:22 a.m., with the Director of Staff Development (DSD), reviewed Resident 110 ' s Medical Diagnosis, Order Summary Report, Medication Administration Record (MAR), and Location of Administration of Insulin Report from 4/2025 to 6/2025. The DSD stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 110. The DSD stated the staff should rotate insulin administration sites to prevent bruising, skin injury, and lipodystrophy on Resident 110. The DSD stated administering insulin in the sites of lipodystrophy can cause malabsorption of the insulin that can cause hypo (low) or hyperglycemia (high blood sugar in the blood stream) on Resident 110. During an interview on 6/6/2025, at 11:14 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should rotate insulin administration sites to maximize absorption of insulin in the fatty tissues. The ADON stated failing to rotate insulin administration sites on Resident 110 can lead to development of lipodystrophy that halts the absorption of insulin causing high or low blood sugar on residents. 2. During a review of Resident 6 ' s admission Record, the admission Record indicated the facility admitted the resident on 4/21/2023, and readmitted on [DATE], with diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease (condition where diabetes damages the kidneys, leading to a slow decline in their ability to filter waste and fluids from the blood) and mild protein-calorie malnutrition. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6 ' s H&P, dated 3/11/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self understood and sometimes understand others and had moderately impaired cognition (refers to a significant decline in cognitive abilities [like thinking, memory, language, and problem-solving] that interferes with a person's ability to carry out everyday activities). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 6 ' s Order Summary Report, indicated an order for: - 5/29/2025 Novolog Flexpen 100 unit/ml Solution pen-injector. Inject as per sliding scale: if 0 - 149 = 0 unit if blood sugar is less than 70 milligrams per deciliter (mg/dL, a unit of measurement that indicates the concentration of a substance, like blood glucose [blood sugar], in a specific volume of fluid [a deciliter, which is 1/10 of a liter]), initiate hypoglycemia protocol and notify MD.; 150 - 199 = 3 units; 200 - 249 = 5 units; 250 - 299 = 8 units; 300 - 349 = 10 units; 350+ = 12 units if blood sugar is greater than 350 mg/dL, notify MD., subcutaneously before meals and at bedtime for type 2 diabetes mellitus. Rotate injection sites. - 4/29/2025 Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 50 unit subcutaneously in the evening for diabetes mellitus (DM) II. During a review of Resident 6 ' s Care Plan (CP) Report titled, At risk for hypoglycemia/hyperglycemia, initiated on 4/25/2025, the CP indicated an intervention to administer medications as ordered. During a review of Resident 6 ' s Location of Insulin Administration Report from 4/2025 to 6/2025, indicated Novolog 100 unit/ml Flexpen was administered on: - 4/26/2025 at 5:48 p.m. on the Arm-right - 4/26/2025 at 8:58 p.m. on the Arm-right - 4/27/2025 at 6:32 a.m. on the Arm-right - 5/11/2025 at 8:56 p.m. on the Arm-left - 5/12/2025 at 6:14 a.m. on the Arm-left - 5/28/2025 at 11:07 a.m. on the Arm-left - 5/28/2025 at 4:57 p.m. on the Arm-left - 5/29/2025 at 1:48 p.m. on the Abdomen-LLQ - 5/29/2025 at 1:48 p.m. on the Abdomen-LLQ (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/5/2025, at 9:42 a.m., with the DSD, reviewed Resident 6 ' s Medical Diagnosis, Order Summary Report, MAR, and Location of Administration of Insulin Report from 4/2025 to 6/2025. The DSD stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 6. The DSD stated the staff should rotate insulin administration sites to prevent bruising, skin injury, and lipodystrophy on Resident 6. The DSD stated administering insulin in the sites of lipodystrophy can cause malabsorption of the insulin that can cause hypo or hyperglycemia on Resident 6. During an interview on 6/6/2025, at 11:14 a.m., with the ADON, the ADON stated the licensed staff should rotate insulin administration sites to maximize absorption of insulin in the fatty tissues. The ADON stated failing to rotate insulin administration sites on Resident 6 can lead to development of lipodystrophy that halts the absorption of insulin causing high or low blood sugar on residents. During a review of the facility's recent policy and procedure (P&P) titled, Diabetic Management, last reviewed on 4/30/2025, the P&P indicated the abdomen, upper arms, thighs, and hips are the four main sites of insulin injection. Rotation of injection sites is recommended to prevent lipodystrophy which may cause a decrease in the absorption of insulin. Encourage the resident to use all available sites within one area rather than randomly rotating sites from area to area. During a review of the facility-provided document Highlights of Prescribing Information on the use of Novolog (Insulin aspart {rDNA origin} injection), solution for subcutaneous use, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement resident-centered activities for one of three sampled residents (Resident 54), reviewed under Activities care area, by failing to: 1. Ensure Resident 54 was provided her preferred activities when Resident 54 was not brought to the religious services. 2. Follow the facility ' s policy and procedure to document and maintain a current record for residents participating for each type of activity for Resident 54. These deficient practices had the potential to result in a decline in Resident 54 ' s physical, social and emotional functioning. Findings: During a review of Resident 54 ' s admission Record, the admission Record indicated the facility admitted the resident on 7/9/2021 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 54 ' s History and Physical (H&P), dated 3/11/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 54 ' s Minimum Data Set (MDS- a resident assessment tool), dated 2/24/2025, the MDS indicated the resident had the ability to understand others and made self understood. The MDS indicated Resident 54 was dependent on staff with chair/bed-to-chair transfers. During a review of Resident 54 ' s MDS, dated [DATE], the MDS indicated that participating in religious services or practices was very important to the resident while residing in the facility. During a review of Resident 54 ' s Activity Progress Note (APN), dated 5/22/2025, the APN indicated the resident ' s current activity preference to participate in religious services for 1:1 visit and to continue with activity Care Plan. During a review of Resident 54 ' s Care Plan (CP) focused on little, or no activity involvement related to physical limitations, revised 9/18/2024, the CP indicated the resident with goals of expressing satisfaction with type of activities and level of activity involvement when asked. The CP indicated interventions including to assist/escort to activity functions by activity department. During an interview on 6/5/2025 at 10:19 a.m. with the Activity Director (AD), the AD stated the Activity Assistants documents daily on the electronic charting. The AD stated they have a separate sheet that shows the residents attendance during group activities. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/5/2025 at 12:56 p.m. with Activity Assistant 1 (AA 1), AA 1 stated religious service is every Thursday and did not come today, 6/5/2025. AA 1 stated for residents in their room the Certified Nursing Assistant (CNA) would bring and inform the residents about the activities. AA 1 stated she did not do room visit yet because she is the only AA today. AA 1 stated on their activity record documentation, active means the resident participated in the activities and passive means they are in their room. AA 1 stated the religious service that comes every Thursday is a Christian mass service but was cancelled today and they changed it with a different activity. During an interview on 6/5/2025 at 1:16 p.m. with Resident 54, Resident 54 stated she would like to be invited when there is a Christian religious service because she needed to be blessed. Resident 54 stated she would like to be told in advance when they come here. Resident 54 stated she used to attend the mass service every week, but it has been months since she last attended. Resident 54 stated it is very important for her to attend because she would like to be blessed. Resident 54 stated if she was invited today, 6/5/2025, she would have attended. Resident 54 stated no one has told her about the mass service today, 6/5/2025. During an interview on 6/5/2025 at 1:20 p.m. with CNA 1, CNA 1 stated Resident 54 did not want to get up today and preferred to stay in her bed. CNA 1 stated he only asked Resident 54 if she would like to get up, but Resident 54 did not want to get out of bed. CNA 1 stated when it comes to activities, the activity staff would let the residents know about the activities for the day. CNA 1 stated he mainly focuses on providing his assigned residents shower, toileting, passing meal trays, and assisting the residents out of bed ready for the day. During an interview on 6/5/2025 at 1:59 p.m. with AA 1, AA 1 stated they document every day about what activities the residents do every day and if they do not document means they did not show their work and would not know if it was done. AA 1 stated she does not have a list of residents who attends religious service, but whoever wants to attend can attend. During an interview on 6/6/2025 at 1:24 p.m. with the AD, the AD stated the AA would do their room rounds and let the residents know about the activities of the day that the residents are aware of the activities. The AD stated AA would bring the residents or if the residents are ready the CNAs would bring them. The AD stated it is the responsibility of the AA to inform the residents of the activities of the day and should inform the residents if there were any changes to the activities. The AD stated the purpose of activities is to provide residents with entertainment, sensory stimulation, and daily awareness including the weather, how the day looks or feels. During a concurrent interview and record review on 6/6/2025 at 1:31 p.m. with the AD, reviewed the facility ' s policy and procedure titled, Activities Program, revised 3/27/2025, and Activities Check-In sheets, for 4/2025 and 5/2025, the AD stated she has not implemented this P&P about tracking attendance for each activity. The AD stated she will implement and follow this P&P. The AD stated she will outline each activity to have more track who attends every activity. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025 at 1:56 p.m. with the Director of Nursing (DON), the DON stated the role of the nursing department when it comes to activities is to provide activities to residents when they notice the resident could use some activities. The DON stated the activity staff would need to inform the residents about the activities of the day. The DON stated when activities, such as religious service, are not being offered to Resident 54 or the non-communication of the cancellation of the religious service, Resident 54 may have sudden change such as increase agitation or anxiety especially residents with dementia. The DON stated Resident 54 may feel spiritually neglected. The DON stated when the religious service is not available, they can also provide prayer or play religious/spiritual music to the resident. During a review of the facility ' s policy and procedure (P&P) titled, Activities Program, reviewed and approved on 4/30/2025, the P&P indicated that the activity care plan should be implemented for each resident and integrated into the individual interdisciplinary resident care plan. The P&P indicated activities should be available daily and maintain a current record of the type and frequency of activities provided and the names of the residents participating in each activity.

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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 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** 2. During a review of Resident 23 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 10/23/2024 and readmitted on [DATE] with diagnoses including cognitive communication deficit (a condition characterized by difficulty with attention, memory, reasoning, planning, organization, and/or language skills), type 2 diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), and generalized muscle weakness. During a review of Resident 23 ' s H&P, dated 10/24/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 23 ' s MDS, dated [DATE], the MDS indicated Resident 23 was able to understand others and make his needs known and with an intact cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicate Resident 23 required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene; total assistance with transfers and lower body dressing; substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 23 had an impairment on both lower extremities. During a review of Resident 23 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order dated 4/16/2025 to transfer Resident 23 to GACH 1. During a review of Resident 23 ' s Progress Notes in the electronic health record (EHR – a person ' s computer-based health record or data) dated 4/16/2025 at 3:56 p.m., the Progress Notes indicated to transfer resident to the hospital. During a review of Resident 23 ' s SNF/NF to Hospital Transfer form dated 4/16/2025, the SNF/HF to Hospital Transfer Form indicated urinary tract infection (UTI - an infection in the bladder/urinary tract) as the reason for transfer to GACH 1. During a concurrent interview and record review on 6/5/2025 at 8:26 a.m., reviewed Resident 23 ' s progress notes, SNF/NF to Hospital Transfer form, eInteract Change of Condition form/SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) with Minimum Data Set Coordinator (MDSC) 1. MDSC 1 stated the progress note indicated Resident 23 was transferred to hospital, the transfer form indicated the reason for Resident 23 ' s transfer to GACH 1 was UTI. MDSC 1 stated there was no eInteract Change of Condition/SBAR completed by the licensed nurse dated 4/16/2025 regarding the events that lead to Resident 23 ' s transfer to GACH 1. MDSC 1 stated every time there is a change in resident ' s condition, the licensed nurse should initiate a change in condition so everyone, including the resident representative would be aware of what happened to the residents. MDSC 1 stated there should have been an eInteract [NAME] of Condition completed for Resident 23 to make everyone aware of what happened with Resident 23 and what were the events that led to the resident ' s transfer to GACH 1and what were the interventions provided to Resident 23. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/6/2025 at 11:30 a.m. with the Director of Nursing (DON), the DON stated the DON stated the licensed nurses are supposed to complete an eInteract Change of Condition/SBAR form in the EHR every time there is a change in resident ' s condition including the diagnosis, assessments, physician ' s orders, and informing of resident/representatives of the change of condition. The DON stated the SBAR/COC records the events that happened to Resident 23 and what diagnosis, assessments, interventions provided to the resident during the crisis. The DON stated the SBAR/COC serves as a communication tool to all healthcare providers and resident representatives of what transpired during the incident to better understand the situation. During a review of the facility ' s recent policy and procedure (P&P), titled Change of Condition – Notification, last reviewed on 4/30/2025, the P&P indicated a purpose to ensure resident, family, legal representatives, and physicians are informed of changes in the resident ' s condition in a timely manner. The P&P further indicated: - Change of Condition related to Attending Physician (AP) notification is defined as when the AP must be notified when any sudden and marked adverse change in the resident ' s condition manifested by signs and symptoms different than usual denote a new problem, complication, or permanent changes in status and require medical assessment, coordination and consultation with the AP and a change in the treatment plan. Documentation: A. A Licensed Nurse will document the following: i. Date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes. ii. The time the Attending Physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received. iii. The time the family/responsible person was contacted. iv. Update the Care Plan to reflect the resident's current status. v. The incident and brief details in the 24-Hour Report. vi. If the resident is transferred to an acute care hospital, complete an inter-facility transfer form. vii. Complete an incident report per Facility policy. Based on interview and record review, the facility failed to identify and provide needed care and services that are resident-centered, in accordance with the resident's preferences, goals for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs for two of three sampled residents (Residents 109 and 23) reviewed for hospitalizations by failing to ensure a change of condition was documented when the residents were transferred to General Acute Care Hospital (GACH). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	These deficient practices had a potential for delay of provision of care and services on Residents 109 and 23 and failure to accurately account for events that triggered the residents ' change in condition. Findings: 1. During a review of Resident 109 ' s admission Record, the admission Record indicated the facility admitted the resident on 12/11/2024, and readmitted on [DATE], with diagnoses including acute osteomyelitis (inflammation of bone or bone marrow, usually due to infection), neuropathic bladder (a condition where the bladder does not function properly due to nerve damage or dysfunction), and obstructive (is a blockage in the urinary tract that prevents urine from draining properly, leading to urine buildup and potential kidney damage) and reflux uropathy (is a condition where urine flows backward from the bladder into the ureters and kidneys instead of draining properly). During a review of Resident 109 ' s History and Physical (H&P), dated 4/11/2025, the H&P indicated the resident was bed-bound, paraplegic (loss of movement and/or sensation, to some degree, of the legs) with lower extremities contracture (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) and bilateral external fixators (s a type of external fixator used to stabilize and support fractured or deformed bones) in both of his lower legs. During a review of Resident 109 ' s Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2025, the MDS indicated the resident had the ability to make self understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 109 ' s Progress Notes, dated 1/31/2025, the Progress Notes indicated Resident 109 was sent out to GACH 2 at 4:20 a.m., via 911 for critical laboratory results. Resident 109 was awake and able to make needs known, all vital signs (v/s, objective measurements of an individual's basic bodily functions that are essential for life) within normal limits (WNL). During a review of Resident 109 ' s Progress Notes, dated 4/2/2025, the Progress Notes indicated a change of condition evaluation for +3 to 4 edema (swelling caused by an excessive accumulation of fluid in the body's tissues, most commonly in the legs and feet) bilateral feet causing redness due to the hardware, skin breakdown and drainage from around the pin. Primary Care Provider responded to continue to monitor and current treatment. During a review of Resident 109 ' s Skilled Nursing Facility (SNF)/Nursing Facility (NF) to Hospital Transfer Form, dated 4/3/2025, the SNF/NF to Hospital Transfer Form indicated the resident was sent to GACH 3 at 12:20 p.m. for worsening edema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025, at 10:01 a.m., with the Director of Staff development (DSD), reviewed Resident 109 ' s Census, Medical Diagnosis, Change of Condition (COC), Progress Notes, SNF/NF to Hospital Transfer Form. The DSD stated Resident 109 was on hospital leave on the following dates 1/31/2025 and 4/3/2025. The DSD stated every time they discharge Resident 109 to the GACH, they need to do a/an Situation, Background, Assessment, and Recommendation (SBAR, is a structured communication framework that can help teams share information about the condition of a patient or team member or about another issue your team needs to address)/COC and SNF/NF to Hospital Transfer Form. The DSD stated she cannot find the SBAR/COC of Resident 109 on 1/31/2025, when the resident got transferred to GACH 2. The DSD stated the Progress Notes only indicated that on 1/31/2025, Resident 109 got transferred to GACH 2 for critical laboratory results. The DSD stated the Progress Notes did not indicate the resident ' s vital signs, primary diagnosis, code status, the narrative of nursing observations, the primary physician notification, and resident representative notification. The DSD stated on 4/2/2025, there was an SBAR/COC created for Resident 109 for worsening edema, however, it was not updated to reflect the resident being transferred to GACH 3 on 4/3/2025, and the name of the provider notified was not indicated on the documentation during transfer. The DSD stated it was important to do a/an SBAR/COC every time a resident gets transferred to GACH to ensure safe transfer and to document accurately what happened during the change of condition and what assessments, interventions, and recommendations were done to manage the residents ' critical condition. During an interview on 6/6/2025, at 11:14 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should have documented the two occasions of Resident 109 ' s transfer to GACH on the electronic health record in the Change of Condition Notification to ensure the resident was provided with appropriate care prior to resident ' s transfer to GACH. The ADON also stated documenting the Change of Condition Notification ensures all the information needed for reporting the change of condition of the resident is readily available for licensed staff to relay to the primary care provider for appropriate management and treatment of the resident ' s condition. The ADON also stated documenting the Change of Condition in the electronic health record captures accurately what transpired during the change of condition and is readily available if needed for purposes of review and quality assurance.

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Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for eight sampled residents (Residents 59, 114, 34, 56, 110, 57, 377 and 6) reviewed under Accidents and two of four sampled residents (Resident 25 and 18) reviewed under Environment facility task, by: 1. Failing to ensure Resident 59 ' s right floor mat did not have the overbed table placed on the top. 2. Failing to ensure Resident 114 ' s left floor mat did not have the overbed table and the right floor mat did not have the visitor ' s chair placed on top. These deficient practices placed Residents 59 and 114 at risk for increased chances of incurring injury such as falls with fracture (a break or crack in a bone) and even death. 3. Failing to ensure the Resident 25 ' s bed frame control was in good repair when the electrical wall outlet did not have a protective cover. 4. Failing to ensure Resident 18 ' s wall baseboard was in good repair when the baseboard was broken and with exposed sharp nails. These deficient practices placed Residents 25 and 18 at risk for injury such as skin tears, accidental burning, or electrocution which may lead to hospitalization. 5. Failing to ensure Resident 56 ' s left sided fall mat (a cushioned floor pad designed to help prevent injury should a person fall) did not have a bedside table on top of it. 6. Failing to ensure Resident 110 did not have a pack of cigarette in his possession. 7. Failing to ensure Resident 57 ' s bed was in lowest position. 8. Failing to ensure Resident 377 and Resident 6 did not have medications left at their bedside. These deficient practices placed Residents 56, 110, 57, and 377 at risk for accidents such as falls with injuries, burns, and medication overdose. Cross reference F584. Findings: 1. During a review of Resident 59 ' s admission Record (AR), the AR indicated the facility originally admitted the resident on 12/11/2024 and readmitted in the facility on 5/27/2025 with diagnoses including urinary tract infection (UTI- an infection in the bladder/urinary tract), type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and generalized muscle weakness. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59 ' s History and Physical (H&P) dated 12/11/2024, the H&P indicated the resident did not have the capacity to make healthcare decisions but able to decide for activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive), and make her needs known. During a review of Resident 59 ' s Minimum Data Set (MDS- a resident assessment tool), dated 5/8/2025, the MDS indicated Resident 59 was able to understand others and make her needs known but with severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 59 required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene; substantial/maximal assistance with bathing and lower body dressing; partial/moderate assistance from staff with all ADLs. During a review of Resident 59 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order dated 6/3/2025 for floor mat on one side and monitor for placement. During a review of Resident 59 ' s fall risk evaluations dated 12/11/2024, 1/18/2025, and 5/27/2025, the fall risk evaluations indicated Resident 59 was a risk for falls. During a review of Resident 59 ' s care plan (CP) on risk for falls initiated on 12/12/2024, the CP indicated to provide a safe environment so Resident 59 will be free from falls for three (3) months. During a concurrent observation and interview on 6/3/3035 at 9:23 a.m. inside Resident 59 ' s room with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 59 ' s overbed table was placed on top of the resident ' s floor mat. CNA 3 stated overbed tables should be repositioned after resident eats and should not be placed on top of the floor mats as the residents can hit the table when they lose balance upon getting out of bed. CNA 3 stated Resident 59 ' s overbed table should have not been placed on top of the floor mat and repositioned after eating to protect Resident 59 from hitting the table and get hurt when she tries to get out of bed and lose her balance. During a concurrent interview and record review on 6/3/2025 at 2:35 p.m., reviewed a photograph of Resident 59 ' s overbed table that was placed on top of the right floor mat with the Director of Staff Development (DSD). The DSD stated Resident 59 overbed table was placed on top of the floor mat. The DSD stated the staff are supposed to reposition any heavy equipment such as the overbed table, visitor, medical equipment and should not be placed on top of the floor mat. The DSD stated the floor mats are used to protect the residents in case of a fall incident. The DSD stated CNA 3 should have repositioned Resident 59 ' s overbed table and not leave on top of the floor mat to protect the resident from any injury when Resident 59 tries to get out of bed and lose her balance. During an interview on 6/3/2025 at 3:15 p.m. with the Assistant Director of Nursing (DON), the ADON stated the staff are supposed to reposition any heavy equipment such as the overbed table, visitor, medical equipment and not be placed on top of the floor mat. The ADON stated the floor mats are used to protect the residents from the impact of a fall. The ADON stated CNA 3 should have repositioned Resident 59 ' s overbed table and not leave on top of the floor mat to protect the resident from any injury when Resident 59 tries to get out of bed and lose her balance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 114 ' s AR, the AR indicated the facility admitted the resident on 1/14/2025 with diagnoses including vascular dementia (a progressive state of decline in mental abilities), history of falling, and generalized muscle weakness. During a review of Resident 114 ' s H&P, dated 1/16/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 114 ' s MDS, dated 4/232025, the MDS indicated Resident 114 was able to understand others and sometimes able to make her needs known but with moderately impaired cognition. The MDS further indicated Resident 114 required total assistance from staff with toileting hygiene and shower transfers; partial/moderate assistance to substantial/maximal assistance from staff with all other ADLs. During a review of Resident 114 ' s Order Summary Report, the Order Summary Report indicated a physician ' s order dated 1/15/2025 for bilateral floor mats every shift. During a review of Resident 114 ' s fall risk evaluations dated 1/29/2025 and 4/23/2025, the fall risk evaluations indicated Resident 114 was a risk for falls. During a concurrent observation and interview on 6/3/3035 at 10:53 a.m. inside Resident 114 ' s room with CNA 4, CNA 4 stated Resident 114 ' s overbed table was placed on top of the resident ' s left floor mat and the visitor chair was placed on top of the right floor mat. CNA 4 stated visitor chairs and overbed tables should be repositioned after use and should not be placed on top of the floor mats as the residents can hit the table or the visitor chair when they try to get out of bed. CNA 4 stated Resident 114 ' s overbed table should have not been placed on top of the floor mat and repositioned after assisting the resident with eating and the visitor chair should have been repositioned at least at the foot of the bed to protect Resident 59 from hitting the table or the chair and get hurt when she tries to get out of bed and lose her balance. During a concurrent interview and record review on 6/3/2025 at 2:38 p.m., reviewed a photograph of Resident 114 ' s overbed table and visitor ' s chair that were placed on top of the bilateral floor mats with the DSD. The DSD stated Resident 114 overbed table and visitor ' s chair was placed on top of the floor mat. The DSD stated the staff are supposed to reposition any heavy equipment such as the overbed table, visitor, medical equipment and should not be placed on top of the floor mat. The DSD stated the floor mats are used to protect the residents in case of a fall incident. The DSD stated CNA 4 should have repositioned Resident 114 ' s overbed table and visitor chair after use and not leave on top of the floor mats to protect the resident from any injury when Resident 114 tries to get out of bed unassisted. During an interview on 6/6/2025 at 11:05 a.m. with the Director of Nursing (DON), the DON stated the staff are supposed to reposition any heavy equipment such as the overbed table, visitor, medical equipment and not be placed on top of the floor mat. The DON stated the floor mats are used to protect the residents from the impact of a fall. The DON stated CNA 4 should have repositioned Resident 114 ' s overbed table and visitor ' s chair and not leave on top of the floor mats to protect the resident from any injury when Resident 114 tries to get out of bed and lose her balance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 25 ' s AR, the AR indicated the facility admitted the resident on 9/11/2021 with diagnoses that included epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]), cognitive communication deficit (trouble communicating because of difficulties with thinking processes, like attention, memory, or reasoning), and mood disorder (a mental health condition that primarily affects emotional state). During a review of Resident 25 ' s MDS, dated [DATE], the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated that the resident required substantial/maximal assistance from staff for bathing, dressing, personal and oral hygiene; and the resident was dependent on staff for mobility. During a review of Resident 25 ' s CP, titled, Fall Prevention initiated 11/23/2021 and last revised 9/30/2025, the CP indicated an intervention to provide the resident with a safe environment. During a concurrent observation and interview on 6/3/2025 at 10:25 a.m., Resident 25 lay awake in bed while CNA 2 was in the resident ' s room. CNA 2 exited the room. Observed an electrical outlet on the wall behind the resident ' s bed with the bed power cord plugged in. Observed the outlet was missing a protective cover exposing the metal outlet receptacle. During an observation on 6/4/2025 at 10:10 am, observed Resident 25 lying in bed awake. Observed the electrical outlet without a protective cover. During a concurrent observation and interview on 6/4/2025 at 10:15 a.m., CNA 2 entered Resident 25 ' s room and stated the outlet on the wall never had a cover. CNA 2 stated CNA 2 did not report the missing cover because the outlet had always been without a cover. During a concurrent observation and interview on 6/4/2025 at 10:30 a.m. with the Maintenance Assistant (MA), the MA entered Resident 25 ' s room. The MA stated all electrical outlets need a cover to prevent anything from getting into the electrical outlet and potentially resulting in a fire or electrical accident in the resident ' s room. The MA stated the electrical outlet behind Resident 25 ' s bed did not have a cover. The MA stated the staff should have reported the missing electrical cover right away, but they did not. During an interview on 6/4/2025 at 2:29 p.m. with the Maintenance Director (MD), the MD stated the MD was not aware Resident 25 ' s outlet did not have a protective cover. The MD stated it was dangerous when the outlet did not have a cover, and the open outlet could potentially cause electrical shock to the staff or resident. During a concurrent interview and record review on 5/9/2025 at 9 a.m., the DON reviewed the facility P&P regarding maintenance service and resident safety. The DON stated electrical outlets should be covered because uncovered outlets are a fire hazard and could potentially cause electrocution in residents and staff. The DON stated when Resident 25 ' s electrical outlet was not covered the facility P&P was not followed with a potential for injury to the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 56 ' s Care Plan (CP) titled Fall Risk, revised on 7/2/2024, the CP indicated the resident is at risk for falls related to impaired mobility and history of cerebral infarction (a condition in which part of the brain becomes damaged due to an insufficient supply of blood) During observation on 6/3/2025, at 11:34 a.m., inside Resident 56 ' s room, Resident 56 ' s fall mat positioned at the left side of the bed with a bedside table on top it. During an interview on 6/5/2025, at 9:34 a.m., with DSD, DSD stated the fall mat is a protection and resident can fall on the side of the table first that could sustain injury such as fracture and laceration. During an interview on 6/5/2025, at 11:30 a.m., with the ADON, the ADON stated there should be no furniture or medical equipment on top of Resident 56 ' s fall mat to reduce chances of injury on the resident in case of falls. The ADON stated the resident can sustain injury such as fracture if resident hit the hard object on top of fall mat. 6. During a review of Resident 110 ' s H&P, dated 4/4/2025, the H&P indicated the resident was status post spinal surgery (had a back surgery), had cerebrovascular accident (when the blood supply to the brain is cut off), and with right sided weakness who was wheelchair bound. During a review of Resident 110 ' s MDS, dated [DATE], the MDS indicated Resident 110 uses tobacco. During a review of Resident 110 ' s care plan dated 5/9/2025, the care plan did not indicate an intervention to safely store cigarette and lighter. During a review of Resident 110 ' s Care Plan Report, initiated on 5/9/2025, the care plan indicated Resident 110 will be safe, not smoke in their room and only smoke in the designated area and monitor resident compliance with facility ' s smoking policy. During an observation on 6/3/2025, at 9:58 a.m., in Resident 110 ' s room, a pack of cigarettes were on Resident 110 ' s wheelchair. During an interview on 6/5/2025, at 8:03 a.m., with the Activity Director (AD), AD stated, cigarette and lighter should be kept in a sealable bag with their name and locked located in the hallway near the reception desk. During an interview on 6/6/2025, at 1:08 p.m., with the ADON, the ADON stated, cigarette storage should be locked and be given to them when it is needed. During a concurrent record review and interview on 6/5/2025, at 9:03 a.m., with DSD, the Letter of Agreement, form dated 4/5/2025, was reviewed. The Letter of Agreement form indicated, All smokers understand that, when not in use, ALL SMOKING ACCESSORIES (cigarettes, lighter, matches, etc.) must be returned to and kept under the control of the smoking attendant. The DSD stated, all smoking accessories should be surrendered, it may cause accidents such as fire, probably hurt themselves, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During review of Resident 57 ' s AR, the AR indicated the facility admitted the resident on 3/25/2025, with diagnoses including hypertension (high blood pressure), epilepsy (a brain disorder that causes seizures due to unusual electrical activity in the brain), cognitive communication deficit, muscle weakness, hemiplegia (a condition where one side of the body is paralyzed or has severe loss of movement and strength) and hemiparesis (a condition where one side of body has weakness) following cerebral infarction (brain tissue damage caused by a blocked blood vessel in the brain) affecting right dominant side. During review of Resident 57 ' s H&P, dated 3/28/2025, the H&P indicated the resident did not have a capacity to understand and make decisions. During a review of Resident 57 ' s MDS, dated [DATE], the MDS indicated the resident had severely impaired decision making and memory recall. The MDS indicated the resident was dependent on mobility and ADLs. During a review of Resident 57 ' s Care Plan Report (CP), dated 5/23/2025, the care plan indicated resident had risk for falls related to poor safety awareness, muscle weakness, seizure disorder and cerebrovascular accident (when blood flow to part of brain is blocked or blood vessel in the brain burst), with intervention to maintain safe environment and keep bed in low position. During concurrent observation and interview on 6/2/2025 at 10:18 a.m., with CNA, inside Resident 57 ' s room, Resident 57 ' s bed was elevated 30 inches off the ground. CNA stated the higher the bed, the higher the chances of resident falling with injury. During an interview on 6/5/2025 at 9:03 a.m., with DSD, the DSD stated that Resident 57 ' s bed should be placed on lowest position according to care plan and can cause harm if this is not followed. During interview on 6/6/2025 at 11:34 a.m., with the ADON, the ADON stated Resident 57 might incur injury when they fall from a high bed and that the bed should be placed in lowest position. 8a. During a review of Resident 377 ' s AR, the AR indicated the facility admitted the resident on 5/23/2025, with diagnoses including essential hypertension, cognitive communication deficit, abnormalities of gait and mobility and muscle weakness During a review of Resident 377 ' s H&P, dated 6/4/2025, the H&P indicated the resident was awake, alert, interactive, able to make needs known and has capacity to make decisions for healthcare purposes. During a review of Resident 377 ' s MDS, dated [DATE], the MDS indicated the resident was able to express ideas and wants and able to understand others. MDS indicated the resident required maximum assistance with maintaining personal hygiene. During a concurrent observation and interview on 6/3/2025 at 9:44 a.m., with Certified Occupational Therapy Assistant (COTA), inside Resident 377 ' s room, Arnicare cream (over the counter topical product to help relieve muscle aches and bruising) was on the resident ' s bedside table. COTA stated that no medication should be left at bedside, as the resident might apply it to areas where it is not intended to be used. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/5/2025 at 9:18 a.m., with the DSD, the DSD stated there is a potential risk of harm if another resident were to walk by, access the medication, and use medication inappropriately. During an interview on 6/6/2025 at 11:32 a.m., with the ADON, the ADON stated Resident 377 ' s Arnicare cream should not have been left at bedside of the resident to prevent other residents from having access to them that can cause adverse effects (undesired effects of the drug) and there should be an order for the medication from a doctor to ensure safety. 8b. During a review of Resident 6 ' s AR, the AR indicated the facility admitted the resident on 4/25/2025, with diagnoses including vascular dementia (a progressive state of decline in mental abilities) unspecified severity without behavioral disturbance, muscle weakness, acute kidney failure and essential hypertension. During a review of Resident 6 ' s H&P, dated 3/11/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 6 ' s MDS, dated [DATE], the MDS indicated the resident ability to make request was limited and can only respond adequately to simple and direct communication. During a review of Resident 6 ' s Order Summary Report, dated 4/25/2025, the Order Summary Report did not indicate the resident had a physician order for Refreshe (lubricating eye drops). During a concurrent observation and interview on 6/3/2025 at 9:37 a.m., with CNA, inside Resident 6 ' s room, a bottle of Refreshe eye drop were at the resident ' s bedside table. The CNA stated the Refreshe eye drop should not be left at bedside and should be reported to medication nurse. During an interview on 6/5/2025 at 9:40 a.m. with the DSD, DSD stated the importance of properly storing medication to prevent improper access and potential misuse by other residents who may pass by. During an interview on 6/6/2025 at 11:32 a.m., with the ADON, ADON stated there should not have any medication at bedside and emphasized importance of a doctor ' s order to ensure safety. During a review of the facility's recent policy and procedure (P&P) titled, Fall Prevention and Management Program, last reviewed on 4/30/2025, the P&P indicated the facility will implement a Fall Prevention and Management Program that supports providing an environment free from the hazards over which the Facility has control. During a review of the facility-provided manufacturer ' s guideline on Floor Mat 1, undated, it indicated Floor Mat 1 is the ideal choice as part of a comprehensive fall prevention program for providing a safe environment for patients at high risk of falling out of bed. When used as a component of a comprehensive fall prevention program, Floor Mat 1 reduces the impact of a fall from bed to help minimize injury. During a review of the facility's recent P&P titled Fall Management Program, last reviewed on 4/30/2025, the P&P indicated the facility will implement a Fall Management Program that supports providing an environment free from fall hazards. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Resident Safety, last reviewed on 4/30/2025, the P&P indicated to provide a safe and hazard free environment. The P&P further indicated that to observe the safety and well-being of the residents, a resident check will be made at least every two hours around the clock by nursing service personnel. The person-centered care plan may require more frequent safety checks. Any facility staff member who identifies an unsafe situation, practice or environmental risk factors should immediately notify their supervisor or charge nurse. During a review of the facility P&P titled, Maintenance Service, last reviewed 4/30/2025, the P&P indicated the purpose of the P&P is to protect the health and safety of residents, visitors, and Facility Staff. The Maintenance Department maintains all areas of the building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the Maintenance Department may include, but are not limited to: - Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. - Maintaining the building in good repair and free from hazards. During a review of the facility P&P titled, Resident Rooms and Environment, last reviewed 4/30/2025, the P&P indicated the purpose of the P&P is to provide residents with a safe, clean, comfortable and homelike environment. The Facility provides residents with a safe, clean, comfortable, and homelike environment. Facility Staff will provide residents with a pleasant environment and person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. Facility Staff aim to create a personalized, homelike atmosphere. During a review of the facility ' s manufacture instructions titled, PrimeMat 2.0 Impact Reduction Fall Mats User Instructions, undated, the instructions indicated the PrimeMat 2.0 is a great option to include in a fall prevention plan. It helps create a safe space for residents who are at high risk of falling out of bed. When used as part of a full fall prevention program, the PrimeMat 2.0 helps reduce injuries from bed falls. During a review of facility ' s recent P&P titled, Medication Storage In The Facility last reviewed on 4/30/2025, the P&P indicated that medications must be stored in a way that other residents would not have access to it. All nurses and aides must report to the charge nurse on duty any medications found at the bedside that is not allowed there and give it to the charge nurse so it can be returned to the family or responsible person. During a review of facility ' s recent policy and procedure titled, Administration Procedures for All Medications, last reviewed on 4/30/2025, the P&P indicated to administer medications in a safe and effective manner. During a review of the facility ' s recent policy and procedure titled, Medication Storage in the Facility, last reviewed on 4/30/2025, the P&P indicated that medications must be stored in a way that other residents would not have access to it. All nurses and aides must report to the charge nurse on duty any medications found at the bedside that is not allowed there and give it to the charge nurse so it can be returned to the family or responsible person. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s P&P titled, Smoking by Residents, reviewed and approved on 4/30/2025, the P&P indicated the purpose of this policy is to provide a safe environment for residents, staff, and visitors. The P&P indicated it is the policy of the facility to accommodate residents who desire to smoke by taking reasonable precautions, providing a safe environment for them, and protecting the non-smoking residents. The P&P indicated designated smoking areas will be well-ventilated and provide adequate protection from harsh weather conditions, such as sun and rain. The P&P indicated the interdisciplinary team will develop an individualized plan for safe storage, use of smoking materials, assistance and required supervision, if necessary, for residents who smoke. The P&P indicated this is documented on the Resident Smoking Assessment, the resident ' s plan of care, and discussed with the resident and responsible party at resident care conference meetings.

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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 with a urinary catheter (FC - a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for one of one sampled resident (Resident 278) reviewed for urinary catheter or UTI by failing to ensure Resident 278 ' s urinary catheter tubing did not have a kink or loop while hanging on the side of the bed. This deficient practice had the potential for Resident 278 ' s urine not to flow freely and which may lead to the development of UTI. Findings: During a review of Resident 278 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 1/24/2023 and readmitted in the facility on 5/22/2025 with diagnoses including obstructive uropathy (a blockage in the urinary tract that prevents urine from flowing out properly), pneumonia (an infection/inflammation in the lungs), and type two (2) diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing. During a review of Resident 278 ' s History and Physical (H&P) dated 5/28/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 278 ' s Minimum Data Set (MDS, a resident assessment tool), dated 5/29/2025, the MDS indicated Resident 278 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 278 had impairment on both lower extremities and required supervision or touching assistance with eating and oral hygiene; partial/moderate assistance with upper body dressing; substantial/maximal assistance to total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 278 ' s Order Summary Report, the Order Summary Report indicated the following physician ' s order dated 5/23/2025: - Foley Catheter (FC): may change FC 24 French (FR – a unit of measurement)/30 milliliters (ml – a unit of measurement) as needed for leaking/occlusion/dislodgement/excessive sedimentations and accidentally pulled out as needed. - FC: may change urinary catheter bag as needed when FC is changed/leaking or soiled as needed. - FC: monitor drainage bag and document the following every shift: sediment, foul odor, hematuria, bladder distention. - Indwelling FC 24FR/30 ml to bedside drainage for obstructive uropathy. Check every shift. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/3/2025 at 10:23 a.m. inside Resident 278 ' s room with Certified Nursing Assistant (CNA) 5, CNA 4 stated Resident 278 ' s urinary catheter tubing had a loop preventing the urine from flowing freely into the bag. CNA 4 stated the urinary catheter tubing had urine in the loop with some white sediments. CNA 4 stated staff responsibility when it comes to care of urinary catheter is to ensure the bag is below the bladder, the bag had privacy cover, and there must be no kink or loop in the tubing. CNA 4 stated if there is a kink or loop the urine cannot flow and cause development of urine infection. CNA 4 stated Resident 278 ' s urinary catheter tubing should not have a loop so the urine can flow freely and prevent backing up to the bladder which can cause development of UTI. During a concurrent interview and interview on 6/6/2025 at 11:20 a.m., reviewed a photograph of Resident 278 ' s urinary catheter with the Director of Nursing (DON). The DON stated one of the standards of practice to prevent the development of UTI on residents with urinary catheter was for the staff to ensure that the urinary catheter tubing did not have a loop or kink all the time to allow the urine to flow freely. The DON stated Resident 278 ' s urinary catheter should have been positioned in a way that there is no loop or kink in the tubing to prevent development of UTI as it had the potential for the urine not to flow freely, and back up into the bladder. During a review of the facility ' s recent policy and procedure (P&P) titled, Catheter – Care of, last reviewed on 4/30/2025, the P&P indicated a purpose to prevent catheter-associated UTI while ensuring that residents are not given indwelling catheter unless medically necessary. The P&P further indicated the catheter and collecting tube will be kept free from kinking and the collection bag will be kept below the level of the bladder.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure residents receiving enteral feeding (EF - also known as tube feeding, a method of supplying nutrients directly into the stomach) received appropriate care and services to prevent complications of EF for one of one sampled resident (Resident 38) reviewed for tube feeding when the licensed nurse failed to rinse the medication syringe thoroughly after medication administration. This deficient practice had the potential to result in Resident 38 experiencing complications associated with enteral feeding such as gastrointestinal (GI, relating to stomach and intestines) problems such as abdominal pain and diarrhea. Findings: During a review of Resident 38 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 4/6/2021 and readmitted in the facility on 6/25/2023 with diagnoses including gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status, dementia (a progressive state of decline in mental abilities), and generalized muscle weakness. During a review of Resident 38 ' s History and Physical (H&P) dated 2/27/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 38 ' s Minimum Data Set (MDS, a resident assessment tool), dated 4/5/2025, the MDS indicated Resident 38 was non-verbal and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 38 had impairment on both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 38 ' s Order Summary Report, the Order Summary Report indicated the following physician ' s orders: - 8/1/2024: EF Order every nigh shift change tubing syringe daily. - 8/1/2024: EF Order every shift crush and dilute medications with water prior to administering via tube feeding as appropriate. - 2/28/2025: EF Order every sift flush GT with10 milliliters (ml – a unit of measurement) of water in between medication administration. - E Order every shift flush GT with 30 ml of water before and after medication administration. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 38 ' s care plan (CP) titled, Tube Feeding (TF)/Nutrition and Hydration, initiated on 6/26/2023 and last revised on 7/24/2024, the CP indicated to change tubing, water bag, and syringe daily and crush medication and dilute with water and administer via GT as a few of the interventions to ensure the resident will be free of complications related to TF and will have minimized signs of aspiration, nausea, vomiting, diarrhea. During an observation on 6/3/2025 at 9:57 a.m. inside Resident 38 ' s room, observed Resident 38 ' s medication syringe inside a plastic storage bag with yellow liquid at the bottom and yellowish white dried powdery substance stuck on the side of the bag. During a concurrent observation and interview on 6/3/2025 at 3:18 p.m., inside Resident 38 ' s room with the Assistant Director of Nursing (ADON), the ADON stated Resident 38 ' s medication syringe was inside a plastic storage bag with yellow liquid at the bottom and yellowish white dried powdery substance stuck on the side of the bag. The ADON stated licensed nurses are supposed to rinse the medication syringes well after each use and place back in the plastic storage bag to ensure the syringe is clean for next use to prevent infection. The ADON stated Resident 38 ' s medication syringe should have been rinsed well by the licensed nurse before placing it back in the plastic storage bag as it placed the resident at risk for GI problems such as abdominal pain and diarrhea. During a review of the facility provided manufacturer ' s guideline The-Pole-Syringe Irrigation Syringe, undated, the manufacturer ' s guideline indicated to rinse the syringe thoroughly after each use.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure parenteral fluids (are liquids that are administered intravenously or by injection to bypass the digestive system) were administered consistent with professional standards of practice for one of one sampled resident (Resident 278) reviewed during a random observation by failing to ensure Resident 278 ' s midline catheter (a long, thin, flexible tube that is inserted into a large vein in the upper arm) indicated the date of the last dressing change. This deficient practice had the potential to place Resident 278 at risk for developing complications such as infection. Findings: During a review of Resident 278 ' s admission Record, the admission Record indicated the facility originally admitted the resident on 1/24/2023 and readmitted in the facility on 5/22/2025 with diagnoses including obstructive uropathy (a blockage in the urinary tract that prevents urine from flowing out properly), pneumonia (an infection/inflammation in the lungs), and type two (2) diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing. During a review of Resident 278 ' s History and Physical (H&P) dated 5/28/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 278 ' s Minimum Data Set (MDS, a resident assessment tool), dated 5/29/2025, the MDS indicated Resident 278 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 278 had impairment on both lower extremities and required supervision or touching assistance with eating and oral hygiene; partial/moderate assistance with upper body dressing; substantial/maximal assistance to total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 278 ' s Order Summary Report, the Order Summary Report indicated the following physician ' s orders dated 5/22/2025: - Flush lumen with normal saline (NS – a saltwater solution) before and after medication administration every shift. - Change peripheral intravenous (IV – within the vein) line and dressing every 48 hours. During a review of Resident 278 ' s care plan (CP) on potential for infection initiated on 5/23/2025, the CP indicated to change IV site per IV therapy protocol as one of the interventions to keep the resident from signs and symptoms of infection. During an observation on 6/23/2025 at 10:23 a.m. inside Resident 278 ' s room, observed Resident 269 lying in bed awake, alert, and responds appropriately with an IV access on the RUA and the transparent dressing was loose and soiled. Resident 269 stated he had a shower the day before and the dressing became loose. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/3/2025 at 3:15 p.m., inside Resident 278 ' s room with the Assistant Director of Nursing (ADON), the ADON stated Resident 278 ' s midline dressing on the left upper arm did not indicate the date it was last changed. The ADON stated midline dressing changes are supposed to be done by the RN every seven days and as needed if soiled, loose, or leaking. The ADON stated Resident 278 ' s midline dressing should have been changed every seven days as scheduled so everyone would be aware of when it was last changed and placed Resident 278 at risk for development of infection on the insertion site which may lead to more complications such as hospitalization. During an interview 6/6/2025 at 11:30 a.m., with the Director of Nursing (DON), the DON stated midline dressing changes are done by the RN supervisor on duty every seven days and as needed if soiled, loose, or leakage. The DON stated RNs are supposed to assess the site every shift for signs and symptoms of infection, swelling, leakage, soiled, and loose dressing. The DON stated Resident 278 ' s midline dressing should have been labeled with the date it was last changed as it placed Resident 278 at risk for development of infection on the insertion site which can lead to hospitalization. The DON stated if Resident 278 ' s midline dressing was not labeled, the staff would not know the last time the midline dressing was last changed. During a review of the facility ' s recent policy and procedure (P&P) titled, Midline Dressing Changes, last reviewed on 4/30/2024, the P&P indicated: - Midline catheter dressings will be changed at specified intervals, or when needed, to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings. - Change midline dressing every 7 days or if it is wet, dirty, not intact, or compromised in any way. - Apply transparent dressing to area making sure to center the dressing over the insertion site. Label with initials, date and time.

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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 observation, interview, and record review, the facility failed to ensure residents who received dialysis (the process of removing waste products and excess fluid from the body using a machine when the kidneys are not able to do so) received treatment consistent with professional standards of practice for one of two sampled residents (Resident 67) reviewed under the Dialysis care area, by: 1. Failing to follow-up with the resident ' s attending physician when Resident 67 missed a dialysis appointment on 5/30/2025. 2. Failing to ensure a dialysis kit (a collection of medical supplies designed to provide immediate care for emergencies, such as bleeding) for dialysis residents was readily available at Resident 67 ' s bedside. These deficient practices had the potential for unidentified complications such as bleeding and bruising and had the potential to result in lack of provision of necessary treatment and services from dialysis treatment. Findings: During a review of Resident 67 ' s admission Record (AR), the AR indicated the facility originally admitted the resident on 10/9/2022 and readmitted on [DATE] with diagnoses including end stage renal disease (ESRD-irreversible kidney failure), hypertension (high blood pressure), and dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed). During a review of Resident 67 ' s History and Physical (H&P), dated 10/11/2024, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 67 ' s Order Summary Report, indicated the following: - Hemodialysis (HD-a treatment that uses a machine and a special filter to remove waste and excess fluid from the blood when your kidneys are not working properly) order: keep dressing to dialysis site dry and intact at all times on right upper chest permacatheter (a long-term, flexible tube used for dialysis treatment), every shift, dated 4/11/2025. - HD order: monitor for signs and symptoms of infection, bleeding drainage and pain on right upper chest permacatheter and notify MD if positive, dated 4/11/2025. - HD every Monday, Wednesday, and Friday, dated 4/29/2025. During a review of Resident 67 ' s Care Plan (CP) focused on HD related to ESRD, revised on 1/16/2025, the CP indicated the resident with goals of no signs and symptoms of complications from dialysis with interventions including to monitor/document/report as needed signs and symptoms of bleeding, hemorrhage (excessive bleeding), and septic shock (severe and potentially life-threatening condition that arises from a systemic infection causing dangerously low blood pressure and organ dysfunction). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/3/2025 at 1:03 p.m. with Licensed Vocational Nurse (LVN) 1 and Resident 67, at Resident 67 ' s bedside, LVN 1 stated there was no dialysis kit at the bedside. LVN 1 stated they usually have it on the wall, but it was not there. Resident 67 stated the last time he saw a dialysis kit was two weeks ago, after his room was cleaned, he has not seen it. LVN 1 stated she checked Resident 67 ' s closet and it was not there. Resident 67 stated it was not in his closet. LVN 1 stated it is important that Resident 67 has the dialysis kit in case of bleeding especially after his dialysis treatment. During a concurrent interview and record review on 6/6/2025 at 2:09 p.m. with the Director of Nursing (DON), reviewed Resident 67 ' s Change in Condition, dated 5/30/2025 and 5/31/2025, and Resident 67 ' s nursing progress notes from 5/30/2025 to 6/1/2025, the DON stated there was no physician follow-up when Resident 67 missed his dialysis appointment on 5/30/2025. The DON stated when the physician does not reply during the shift when it was identified then the next shift would need to follow up. The DON stated it can be either the LVN or a Registered Nurse (RN) supervisor can do the follow-up. The DON stated when the physician does not answer the licensed nurse would need to call again in an hour and still no response then the next shift should have followed up. The DON stated when the follow-up with the physician is not done, they cannot do critical decisions if the resident deteriorates because there was no timely notification and orders. The DON stated Resident 67 could experience fluid overload, hyperkalemia (high potassium levels in the blood), and cardiac problems. During an interview on 6/6/2025 at 2:28 p.m. with the DON, the DON stated each resident on dialysis should have a dialysis kit at the bedside. The DON stated in case of emergency, such as bleeding, nursing staff would apply pressure on the site, call 911 (emergency services), and notify the resident ' s physician. The DON stated the dialysis kit would contain a gauze, tourniquet, gauze wrap, and square gauzes to be used when applying direct pressure on the dialysis site. The DON stated the dialysis kit is prepared upon admission. The DON stated the purpose of the dialysis kit is to make sure they provide pressure right away and immediate response to stop the bleeding from the resident ' s dialysis site. The DON stated when there is a delay of response, they could place the resident at risk for hemorrhage, hypotension (low blood pressure) or shock (a life-threatening condition where the body's organs and tissues are not receiving enough blood flow and oxygen). During a review of the facility ' s policy and procedures titled, Dialysis Management, reviewed and approved on 4/30/2025, the P&P indicated the facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents ' goals and preferences. During a review of the facility ' s P&P titled, Dialysis Care, reviewed and approved on 4/30/2025, the P&P indicated the nursing staff will keep the attending physician, the resident, and the resident ' s family informed of any change in conditions. The P&P indicated dialysis care for catheter includes monitoring site for bleeding and drainage. The P&P indicated nursing staff will be trained on emergency care for residents with renal disease and dialysis care such as hemorrhage from dislodging (knock or force out of position) of the catheter.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to obtain a physician's order, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), bedrail (an adjustable metal or rigid plastic bars attached to the sides of a bed to assist patients or residents) assessment, and care plan on the use of padded bilateral upper bedrails for one of one sampled resident (Resident 110) reviewed for bedrails. These deficient practices placed the residents at risk for potential accidents such as a body part being caught between the rails, falls if a resident attempts to climb over, around, between, or through the rails. Findings: During a review of Resident 110's admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial muscular weakness or partial paralysis affecting only one side of the body) following cerebral infarction (a serious condition where a section of the brain is deprived of blood flow, leading to tissue death), muscle weakness, and cognitive communication deficit (occurs when someone experiences difficulties with communication due to issues with cognitive processes rather than problems with their speech or language). During a review of Resident 110's History and Physical (H&P), dated 4/4/2025, the H&P indicated the resident had the capacity to understand and make medical decisions. During a review of Resident 110's Minimum Data Set (MDS - a resident assessment tool), dated 4/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident had both lower extremity impairment and uses a walker and wheelchair to ambulate. The MDS indicated the resident was dependent to requiring supervision on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 110's Order Summary Report, dated 6/5/2025, the Order Summary Report did not indicate any physician's order for bedrails. During a review of Resident 110's Fall Risk Evaluation, dated 4/3/2025, the Fall Risk Evaluation indicated the resident was high risk for potential falls. During a concurrent observation and interview on 6/5/2025 at 8:13 a.m. with Certified Nursing Assistant (CNA) 5 inside Resident 110's room, Resident 110's bed had bilateral upper padded bedrails/side rails on. CNA 5 stated the resident had the bedrail to facilitate mobility in bed. CNA 5 stated the bedrails is also used as a fall intervention to limit the resident from getting out of the bed to prevent falls. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/5/2025 at 9:06 a.m. with the Director of Staff Development (DSD), Resident 110's Order Summary Report, Informed Consent, Bedrail Assessment, and Care Plan were reviewed. The DSD stated there was no physician's order for bilateral padded upper bedrail/side rail, no informed consent on the use of the bedrail, and no care plan on the use of bedrails. The DSD stated there was a bedrail assessment however the recommendation was not to use a bedrail. The DSD stated it was important to have a physician's order, bedrail assessment, and care plan to ensure its safe use and to prevent bed entrapment (when a resident becomes caught, trapped, or entangled in the spaces in or about the bed rail, mattress or hospital bed frame). The DSD stated an informed consent is needed prior to the application of the bedrail to honor the right of the resident to informed consent and to give the resident or representative time to agree or disagree to proposed treatment. During an interview on 6/6/2025 at 11:14 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should have obtained a physician's order, informed consent, bedrail assessment, and a care plan on the use of padded upper siderails/bedrails on Resident 110 to ensure its safe use. The ADON stated the care plan serves as communication to the interdisciplinary team (IDT - a group of professionals who work together to provide the best care for a resident) of interventions agreed upon by the IDT to standardize the care provided to the resident. The ADON stated they needed an informed consent from the resident or representative to honor their right to agree or disagree to the proposed treatment. During a review of the facility's recent policy and procedure (P&P) titled, Bed Rails, last reviewed on 4/30/2025, the P&P indicated to provide guidance to adequately evaluate the use of bed rails and prevent potential entrapment or other safety hazards. A bed rail is an assistive device and must be used in accordance with the following regulations: C. The length of the bed rail (quarter, half, full, etc.) does not determine if the bed rail is a restraint or an enabler. E. A detailed order by a healthcare provider (e.g. a physician, nurse practitioner) is required before any restraints can be utilized. During a review of the facility's recent P&P titled Informed Consent, last reviewed on 4/30/2025, the P&P indicated the licensed nurse will confirm that the Healthcare Practitioner obtained informed consent and will document the verification in the Resident's medical record, before administering the first dose or first increased dose of psychoactive medications, applying physical restraints or medical devices. Documenting of the verification of informed consent may be done by: i. Contacting the Resident or decision-maker (including Surrogate IDT) to verify that the Healthcare Practitioner obtained informed consent for the order. During a review of the facility's recent P&P titled Comprehensive Person-Centered Care Planning, last reviewed on 4/30/2025, the P&P indicated within 7 days from the completion of the comprehensive care plan will be developed. All goals, objectives, interventions, etc. from the current baseline care plan will be included in the resident's comprehensive care plan.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to: 1. Reconcile (the process of comparing transactions and activity to supporting documentation) and account for six (6) medication emergency kit (eKIT) containing Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs or Controlled Substances [CS]) for June 2025, in three (3) of three (3) inspected Medication Rooms (Medication Room Station 1, Station 2 and Station 3). As a result, control and accountability of medications and CMs did not follow state and federal regulations and facility policy and procedures. 2. Have an available supply of tramadol (a medication used to treat pain) in the facility affecting 1 (one) of six (six) observed residents (Resident 8) for medication administration. As a result, Resident 8 did not receive tramadol on 6/3/2025 at 9:06 a.m. These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use) and the risk that residents in the facility could have adverse drug reactions (unwanted, uncomfortable, or dangerous effects that a medication may have, such as coma [a state of deep unconsciousness]) from exposure to harmful medications, leading to hospitalization, and the potential to cause Resident 8 to experience continued pain resulting in psychosocial harm. Cross-reference F759. Findings: During an observation on 6/3/2025 at 9:06 a.m. in Medication Cart 3B, Licensed Vocational Nurse (LVN) 2 was observed administering amlodipine (a medication used for high blood pressure,) isosorbide (a medication used for high blood pressure), docusate (a medication used for bowel [intestine] management), and Tylenol (a medication used for pain) orally to Resident 8, and was observed not administering tramadol to Resident 8. During an interview on 6/3/2025 at 11:52 a.m. with LVN 2, LVN 2 stated that LVN 2 did not administer tramadol that day (6/3/2025) at 9:06 a.m. to Resident 8, as prescribed by Resident 8's physician, since tramadol was not available in Medication Cart 3B or in the facility. LVN 2 stated Resident 8 stated a pain level of 5 that day (6/3/2025) at 8:50 a.m., and LVN 2 administered Tylenol since that was the only pain medication available. LVN 2 acknowledged Tylenol was prescribed by Resident 8's physician for pain level between 1 and 4. LVN 2 stated this was considered a medication error. LVN 2 stated medications should be ordered five (5) days in advance and be readily available to ensure timely administration at the scheduled times. LVN 2 stated tramadol was a medication used to relieve severe pain (pain level 5 and above) and not administering tramadol when needed can harm Resident 8 by not relieving the pain and leading to worsening of the pain. LVN 2 stated LVN 2 will reorder tramadol from pharmacy and notify Resident 8's physician of not administering tramadol to Resident 8 and obtain additional orders as necessary. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 6/4/2025 at 9:35 a.m. with LVN 1 in Medication Room Station 2, there were: 1. One (1) medication eKIT stored in the refrigerator and labeled 59, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. 2. One (1) medication eKIT stored in a cabinet and labeled 264, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. LVN 1 stated that all CMs, including medication eKITs containing CMs should be reconciled at every shift. LVN 1 stated that two (2) eKITs labeled 59 and 264 containing CMs in Medication Room Station 2 were not reconciled at every shift in June 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During an observation on 6/4/2025 at 9:55 a.m. with Registered Nurse (RN) 2 in Medication Room Station 3, RN 2 confirmed there were: 1. One (1) medication eKIT stored in the refrigerator and labeled 231, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. 2. One (1) medication eKIT stored in a cabinet and labeled 257, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. During an interview on 6/4/2025 at 10:08 a.m. with LVN 3, LVN 3 stated that all CMs should be reconciled at every shift. LVN 3 stated the medication eKITs labeled 231 and 257 containing CMs in Medication Room Station 3 were not reconciled at every shift for June 2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances and to prevent overdose to residents. During a concurrent observation and interview on 6/4/2025 at 10:23 a.m. with LVN 4 in Medication Room Station 1, there were: 1. One (1) medication eKIT stored in the refrigerator and labeled 170, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. 2. One (1) medication eKIT stored in a cabinet and labeled 64, containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for June 2025. LVN 4 stated that all CMs, including medication eKITs containing CMs should be reconciled at every shift. LVN 4 stated two (2) medication eKITs labeled 64 and 170 containing CMs in Medication Room Station 1 were not reconciled at every shift in June 2025. LVN 4 stated it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 6/4/2025 at 3:08 p.m. with the Director of Nursing (DON), the DON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated six (6) eKITs containing CMs in three (3) Medication Rooms: Station 1, 2 and 3 in the facility did not have accountability and reconciliation logs at each shift change for June 2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of all eKITs containing CMs at each shift change in all Medication Room Stations. During the same interview, the DON stated that per facility policy medications should be readily available for administration, and pain medications should be administered as ordered by the physician. The DON stated LVN 2 failed to administer tramadol to Resident 8 on 6/3/2025 at 9:06 a.m. since tramadol was not available in the facility and instead administered Tylenol. The DON stated this was considered a medication error. The DON stated tramadol was prescribed by Resident 8's physician for pain level between 5 and 10, and Tylenol was prescribed for pain level between 1 and 4, not administering the right pain medication for the indicated pain level can potentially harm Resident 8 by not relieving the pain and worsening to higher levels. During a review of Resident 8's admission Record (a document containing demographic and diagnostic information), the admission Record indicated the facility originally admitted Resident 8 on 1/19/2024 and re-admitted on [DATE] with diagnoses including spondylosis (a worsening osteoarthritis [a condition where the cushion between joints breaks down over time, causing pain, stiffness, and reduced movement] of the spine) and cervical disc degeneration (a progressive condition where the cushioning discs in the cervical spine [neck] break down due to aging and wear and tear causing pain). During a review of Resident 8's Order Summary Report (a report listing the physician order for the resident), dated 6/3/2025, the Order Summary Report indicated Resident 8 was prescribed tramadol 50 milligram ([mg] - a unit of measure of mass) one (1) tablet orally every eight (8) hours as needed for moderate to severe pain 5 to 10, starting 5/31/2025. During a review of Resident 8's Medication Administration Record (MAR - a record of mediations administered to residents,) for June 2025, the MAR indicated Resident 8 was prescribed tramadol 50 mg to give one (1) tablet orally every eight (8) hours as needed for moderate to severe pain 5 to 10, and Resident 8 not administered tramadol 50 mg on 6/3/2025 at 9:06 a.m. During a review of the facility's policy and procedure (P&P) titled, Administration Procedures for All Medications, last reviewed 4/30/2025, the P&P indicated to administer medications in a safe and effective manner. The P&P indicated to review the five rights (right resident, right drug, right dose, right route and right time) three times and to check the label against the order on the MAR. During a review of the facility's P&P titled Medication Administration - General Guidelines, last reviewed 4/30/2025, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices . Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Preparation 4. Five Rights - right resident, right drug, right dose, right route and right time, are applied for each medication being administration. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5. Prior to administration of any medication, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different .the physician's orders are checked for the correct dosage schedule. Administration 2. Medications are administered in accordance with written orders of the prescriber. During a review of the facility's P&P titled Pain Management, last reviewed 4/30/2025, the P&P indicated: Facility staff will help the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain to the extent possible. A. The Licensed Nurse will administer pain medication as ordered . During a review of the facility's P&P titled Controlled Substances, last reviewed 4/30/2025, the P&P indicated: Medications included in the Drug Enforcement Administration classification as CS are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the Consultant Pharmacist in collaboration maintain the facility's compliance with federal and state laws and regulations in the handling of CMs. 1. Accurate accountability of the inventory of all controlled drugs is maintained at all times. During a review of the facility's P&P titled Emergency Pharmacy Service and Emergency Kits, last reviewed 4/30/2025, the P&P indicated: 3) The incoming and outgoing nurses verify the inventory is verified at each change of shift or exchange of keys. During a review of the facility's P&P titled Controlled Medications - Storage and Reconciliation, last reviewed 4/30/2025, the P&P indicated: Medications included in the Drug Enforcement Administration classification as CS are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The Director of Nursing Services and the Consultant Pharmacist maintains the facility's compliance with federal and state laws and regulations in the handling of Controlled substances. At each shift change, or when keys are transferred, a physical inventory of all Controlled substances, including refrigerated items conducted by two (2) licensed nurses and is documented.

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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 (%). Two (2) medication errors out of 31 total opportunities contributed to an overall medication error rate of 6.45% affecting two (2) of six (6) residents observed for medication administration (Resident 8 and 87). The medication errors were as follows: 1. Resident 8 did not receive tramadol (a medication used to treat pain) on 6/3/2025 at 9:06 a.m., as prescribed by Resident 8's physician. 2. Resident 87 received a form of multivitamin (a medication used as a dietary supplement for wound healing) that was different than the one ordered by Resident 87's physician. These failures had the potential for Residents 8 and 87 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and health complication, such as continuous and unrelieved pain, resulting in Resident 8's and 87's health and well-being to be negatively impacted. Cross-reference F755. Findings: During an observation on 6/3/2025 at 8:44 a.m. in Medication Cart 3B, Licensed Vocational Nurse (LVN) 2 administered benazepril (a medication used for high blood pressure), potassium chloride (a medication used for low potassium blood levels), and multivitamin with mineral tablets orally to Resident 87. Resident 87 swallowed the benazepril, potassium chloride, and multivitamin with mineral tablet with a glass of juice. During an observation on 6/3/2025 at 9:06 a.m. in Medication Cart 3B, LVN 2 administered amlodipine (a medication used for high blood pressure), isosorbide (a medication used for high blood pressure), docusate (a medication used for bowel [intestine] management), and Tylenol (a medication used for pain) orally to Resident 8. LVN 2 did not administer tramadol to Resident 8. During an interview on 6/3/2025 at 11:52 a.m. with LVN 2, LVN 2 stated that LVN 2 acknowledged Resident 87's physician order specified to administer multivitamin not containing minerals. LVN 2 stated that LVN 2 failed to follow the five (5) rights of medication administration (right resident, right drug, right dose, right route, and right time) and failed to administer the correct multivitamin as prescribed by Resident 87's physician that day (6/3/2025) at 8:44 a.m. LVN 2 stated administering multivitamin with minerals to Resident 87 may not be beneficial to the resident's health and may cause adverse effects. LVN 2 stated this was considered a medication error. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same interview, LVN 2 stated that LVN 2 did not administer tramadol that day (6/3/2025) at 9:06 a.m. to Resident 8, as prescribed by Resident 8's physician, since tramadol was not available in Medication Cart 3B or in the facility. LVN 2 stated Resident 8 stated a pain level of 5 that day (6/3/2025) at 8:50 a.m., and LVN 2 administered Tylenol since that was the only pain medication available. LVN 2 acknowledged Tylenol was prescribed by Resident 8's physician for pain level between one (1) and four (4). LVN 2 stated this was considered a medication error. LVN 2 stated that medications should be ordered 5 days in advance and be readily available to ensure timely administration at the scheduled times. LVN 2 stated tramadol was a medication used to relieve severe pain (pain level 5 and above) and not administering when needed can harm Resident 8 by not relieving the pain and leading to worsening of the pain. During an interview on 6/4/2025 at 3:08 p.m. with the Director of Nursing (DON), the DON stated LVN 2 failed to administer multivitamin without minerals to Resident 87 according to the physician orders on 6/3/2025. The DON stated this was considered medication error. The DON stated Resident 87 may possibly be at risk of not being able to tolerate the additional minerals from the multivitamin. The DON stated licensed nurses should follow facility medication administration guidelines and five rights of medication administration to ensure physician orders are followed and the right medications are administered to residents. The DON stated that per facility policy medications should be readily available for administration, and pain medications should be administered as ordered by the physician. The DON stated LVN 2 failed to administer tramadol to Resident 8 on 6/3/2025 at 9:06 a.m. since tramadol was not available in the facility and instead administered Tylenol. The DON stated this was considered medication error. The DON stated tramadol was prescribed by Resident 8's physician for pain level between 5 and 10, and Tylenol was prescribed for pain level between 1 and 4, not administering the right pain medication for the indicated pain level can potentially harm Resident 8 by not relieving the pain and worsening to higher levels. During a review of Resident 8's admission Record (a document containing demographic and diagnostic information), the admission Record indicated Resident 8 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including spondylosis (a worsening osteoarthritis [a condition where the cushion between joints breaks down over time, causing pain, stiffness, and reduced movement] of the spine) and cervical disc degeneration (a progressive condition where the cushioning discs in the cervical spine (neck) break down due to aging and wear and tear causing pain). During a review of Resident 8's Order Summary Report (a report listing the physician order for the resident), dated 6/3/2025, the report indicated Resident 8 was prescribed tramadol 50 milligram (mg - a unit of measure of mass) 1 tablet orally every eight (8) hours as needed for moderate to severe pain 5 to 10, starting 5/31/2025. During a review of Resident 8's Medication Administration Record (MAR - a record of mediations administered to residents), for June 2025, the MAR indicated Resident 8 was prescribed tramadol 50 mg to give 1 tablet orally every 8 hours as needed for moderate to severe pain 5 to 10, and Resident 8 not administered tramadol 50 mg on 6/3/2025 at 9:06 a.m. During a review of Resident 87's admission Record, dated 6/3/2025, the record indicated Resident 87 was originally admitted to the facility on [DATE] with a diagnosis including hypertension (having high blood pressure) and left lower leg wound. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 87's Order Summary Report, dated 6/3/2025, the report indicated Resident 87 was prescribed multivitamin 1 tablet orally once a day for supplement, starting 9/13/2023. During a review of Resident 87's MAR, for June 2025, the MAR indicated Resident 87 was prescribed multivitamin 1 tablet to be given orally once a day for supplement, at 9 a.m. During a review of the facility's Policy and Procedures (P&P) titled, Administration Procedures for All Medications, last reviewed 4/30/2025, the P&P indicated To administer medications in a safe and effective manner . C. Review 5 Rights (3) times. Check the label against the order on the MAR. During a review of the facility's P&P titled, Medication Administration - General Guidelines, last reviewed 4/30/2025, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices . Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Preparation 4. Five Rights - right resident, right drug, right dose, right route and right time, are applied for each medication being administration. 5. Prior to administration of any medication, the medication ad dosage schedule on the resident's MAR is compared with the medication label. If the label and MAR are different .the physician's orders are checked for the correct dosage schedule. Administration 2. Medications are administered in accordance with written orders of the prescriber. During a review of the facility's P&P titled, Pain Management, last reviewed 4/30/2025, the P&P indicated: Facility staff will help the resident attain or maintain their highest level of well-being while working to prevent or manage the resident's pain to the extent possible. A. The Licensed Nurse will administer pain medication as ordered . During a review of the facility's P&P titled, Medication Errors, last reviewed 4/30/2025, the P&P indicated Medication error means the administration of medication: E. which is not currently prescribed.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of five sampled residents (Residents 110 and 6) reviewed for unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq - beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F658. Findings: 1. During a review of Resident 110's admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025, with diagnoses including type two (2) diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, and mild protein-calorie malnutrition (is a nutritional deficiency resulting from inadequate intake of both protein and energy). During a review of Resident 110's History and Physical (H&P), dated 4/4/2025, the H&P indicated the resident was able to understand and make medical decisions. During a review of Resident 110's Minimum Data Set (MDS - a resident assessment tool), dated 4/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a class of drugs used to lower blood sugar levels, often in the treatment of type 2 diabetes). During a review of Resident 110's Order Summary Report, dated 5/24/2025, the Order Summary Report indicated an order of Novolog 100 units per milliliter (unit/ml - refers to the concentration of insulin) Flexpen. Inject as per sliding scale (increasing administration of the pre?meal insulin dose based on the blood sugar level before the meal): if 70 - 150 = 0 unit; 151 - 200 = 2 units; 201 - 250 = four (4) units; 251 - 300 = six (6) units; 301 - 350 = eight (8) units; 351 - 400 = 10 units; 401+ = 12 units, subcutaneously before meals and at bedtime for DM type 2 BS below 70 initiate hypoglycemia protocol (a set of procedures used to manage low blood sugar [hypoglycemia], typically in individuals with diabetes). Call MD if blood sugar (BS) below 70 or above 400. Rotate injection sites. During a review of Resident 110's Location of Insulin Administration Report, from 4/2025 to 6/2025, the Location of Insulin Administration Report indicated Novolog 100 unit/ml Flexpen was administered on: (continued on next page)

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	056380	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/8/2025 at 12:12 p.m. on the Abdomen-Left Lower Quadrant (LLQ) 4/9/2025 at 12:16 p.m. on the Abdomen-LLQ 4/10/2025 at 4:48 p.m. on the Arm-right 4/11/2025 at 5:39 p.m. on the Arm-right 4/12/2025 at 4:58 p.m. on the Arm-right 4/15/2025 at 8:55 p.m. on the Arm-right 4/17/2025 at 5:43 p.m. on the Arm-right 5/8/2025 at 8:36 p.m. on the Arm-left 5/9/2025 at 8:20 p.m. on the Arm-left 5/10/2025 at 5:27 p.m. on the Arm-right 5/11/2025 at 7:48 p.m. on the Arm-right 5/30/2025 at 5:02 p.m. on the Arm-right 5/31/2025 at 4:43 p.m. on the Arm-right During a concurrent interview and record review on 6/5/2025 at 9:22 a.m. with the Director of Staff Development (DSD), Resident 110's Medical Diagnosis, Order Summary Report, Medication Administration Record (MAR), and Location of Administration of Insulin Report, from 4/2025 to 6/2025, were reviewed. The DSD stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 110. The DSD stated the staff should rotate insulin administration sites to prevent bruising, skin injury, and lipodystrophy on Resident 110. The DSD stated administering insulin in the sites of lipodystrophy can cause malabsorption of the insulin that can cause hypo (low) or hyperglycemia (high blood sugar levels in the bloodstream) on Resident 110. The DSD stated not rotating insulin administration sites is a medication error. During an interview on 6/6/2025 at 11:14 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should rotate insulin administration sites to maximize absorption of insulin in the fatty tissues. The ADON stated failing to rotate insulin administration sites on Resident 110 can lead to development of lipodystrophy that halts the absorption of insulin causing high or low blood sugar on residents. The ADON stated not rotating insulin administration site is a form of medication error. During a review of the facility's recent policy and procedure (P&P) titled, Medication-Errors, last reviewed on 4/30/2025, the P&P indicated medication error means the administration of medication: A. To the wrong resident; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. At the wrong time; C. At the wrong dose; D. Via the wrong route; or E. Which is not currently prescribed. During a review of the facility's recent P&P titled, Diabetic Management, last reviewed on 4/30/2025, the P&P indicated the abdomen, upper arms, thighs, and hips are the four main sites of insulin injection. Rotation of injection sites is recommended to prevent lipodystrophy which may cause a decrease in the absorption of insulin. Encourage the resident to use all available sites within one area rather than randomly rotating sites from area to area. During a review of the facility-provided Highlights of Prescribing Information on the use of Novolog (Insulin aspart {rDNA origin} injection), solution for subcutaneous use, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy. 2. During a review of Resident 6's admission Record, the admission Record indicated the facility admitted the resident on 4/21/2023, and readmitted the resident on 4/25/2025, with diagnoses including type 2 diabetes mellitus with diabetic chronic kidney disease (a progressive condition where the kidneys are damaged due to high blood sugar levels, often seen in people with diabetes) and mild protein-calorie malnutrition. During a review of Resident 6's H&P, dated 3/11/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 6's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and sometimes understand others and had moderately impaired cognition (refers to a noticeable decline in a person's thinking abilities that impacts their daily life). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 6's Order Summary Report, the Order Summary Report indicated orders for: On 5/29/2025, Novolog Flexpen 100 unit/ml Solution pen-injector. Inject as per sliding scale: if 0 - 149 = 0 unit if blood sugar is less than 70 milligrams per deciliter (mg/dL - the unit of measurement for blood sugar levels, showing how much glucose (sugar) is in a specific volume of blood), initiate hypoglycemia protocol and notify MD.; 150 - 199 = three (3) units; 200 - 249 = five (5) units; 250 - 299 = 8 units; 300 - 349 = 10 units; 350+ = 12 units if blood sugar is greater than 350mg/dL, notify MD., subcutaneously before meals and at bedtime for type 2 diabetes mellitus. Rotate injection sites. On 4/29/2025, Insulin Glargine Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine). Inject 50 unit subcutaneously in the evening for DMII. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 6's Care Plan (CP) Report titled At risk for hypoglycemia/hyperglycemia, initiated on 4/25/2025, the CP indicated an intervention to administer medications as ordered. During a review of Resident 6's Location of Insulin Administration Report from 4/2025 to 6/2025, indicated Novolog 100 unit/ml Flexpen was administered on: 4/26/2025 at 5:48 p.m. on the Arm-right 4/26/2025 at 8:58 p.m. on the Arm-right 4/27/2025 at 6:32 a.m. on the Arm-right 5/11/2025 at 8:56 p.m. on the Arm-left 5/12/2025 at 6:14 a.m. on the Arm-left 5/28/2025 at 11:07 a.m. on the Arm-left 5/28/2025 at 4:57 p.m. on the Arm-left 5/29/2025 at 1:48 p.m. on the Abdomen-LLQ 5/29/2025 at 1:48 p.m. on the Abdomen-LLQ During a concurrent interview and record review on 6/5/2025 at 9:42 a.m. with the DSD, Resident 6's Medical Diagnosis, Order Summary Report, MAR, and Location of Administration of Insulin Report, from 4/2025 to 6/2025, was reviewed. The DSD stated there were multiple instances that the licensed staff did not rotate the insulin administration sites on Resident 6. The DSD stated the staff should rotate insulin administration sites to prevent bruising, skin injury, and lipodystrophy on Resident 6. The DSD stated administering insulin in the sites of lipodystrophy can cause malabsorption of the insulin that can cause hypo or hyperglycemia on Resident 6. The DSD stated not rotating insulin administration sites is a medication error. During an interview on 6/6/2025 at 11:14 a.m. with the ADON, the ADON stated the licensed staff should rotated insulin administration sites to maximize absorption of insulin in the fatty tissues. The ADON stated failing to rotate insulin administration sites on Resident 6 can lead to development of lipodystrophy that halts the absorption of insulin causing high or low blood sugar on residents. The ADON stated not rotating insulin administration site is a form of medication error. During a review of the facility's recent P&P titled, Medication-Errors, last reviewed on 4/30/2025, the P&P indicated medication error means the administration of medication: A. To the wrong resident; B. At the wrong time; C. At the wrong dose; (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Via the wrong route; or E. Which is not currently prescribed. During a review of the facility's recent P&P titled, Diabetic Management, last reviewed on 4/30/2025, the P&P indicated the abdomen, upper arms, thighs, and hips are the four main sites of insulin injection. Rotation of injection sites is recommended to prevent lipodystrophy which may cause a decrease in the absorption of insulin. Encourage the resident to use all available sites within one area rather than randomly rotating sites from area to area. During a review of the facility-provided Highlights of Prescribing Information on the use of Novolog (Insulin aspart {rDNA origin} injection), solution for subcutaneous use, with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate insulin injection or infusion sites within the same region to reduce the risk of lipodystrophy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 2. During a concurrent interview and observation on 6/4/2025 at 9:55 a.m. with RN 1, in Medication Room Station 3, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) opened epoetin alfa multi-dose (containing more than one dose) vial for Resident 81 stored in the refrigerator containing unused volume of medication and without a date indicating when use first began or when the medication would expire. The manufacturer's product storage and labeling indicated epoetin multi-dose vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and to throw away the vial no later than 21 days from first use. RN 1 stated Resident 81's epoetin alfa vial was open and used, with some volume of medication remining in the vial and continued to be stored in the refrigerator without a date indicating when it was opened or when it would expire. RN 1 stated open multi-dose vials were usually good for 28 days and the epoetin vial for Resident 81 was considered expired since the expiration date was unknown. RN 1 stated expired epoetin vial has decreased medication potency (effectiveness) and when used in error could be ineffective by not treating or controlling Resident 81's anemia, requiring additional treatments. RN 1 stated the epoetin vial for Resident 81 needed to be removed from the refrigerator and disposed of to prevent accidental use. During an interview on 6/4/2025 at 3:08 p.m. with the DON, the DON stated multi-dose medications like epoetin alfa vials should be labeled with the date the vial was opened and discarded usually after 28 days. The DON stated epoetin alfa vials without an open date are considered expired, have lost effectiveness, and should be removed from use and discarded to prevent accidental use. The DON stated administering expired epoetin alfa in error will not be effective and can harm Resident 81 by not treating the anemia. The DON stated several licensed nurses failed to label the epoetin alfa vial for Resident 81 with a date and failed to remove the vial from use, from the refrigerator in Medication Room Station 3. During a review of the facility's policy and procedure (P&P) titled, Administration Procedures for All Medications, last reviewed 4/30/2025, the P&P indicated To administer medications in a safe and effective manner . C. Review 5 Rights (3) times. Check the label against the order on the MAR. D. When opening a multi-dose container, place the date on the container. E. Identify resident using two identification methods before administering medication. During a review of facility's P&P titled, Vials and Ampules of Injectable Medications, last reviewed 4/30/2025, the P&P indicated: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal . (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Opening a vial triggers a shortened expiration date that is unique to the product. The date opened and this triggered expiration date are both important to be recorded on multidose vials. At a minimum the date opened must be recorded. Triggered expiration dates may be founded in the manufacturer's package insert, on the package, provided, or on a reference chart by the pharmacy, or by contacting the pharmacist. During a review of Highlights of Prescribing Information for epoetin alfa, dated 4/2023, the document indicated: Store Retacrit in the refrigerator between 36°F to 46°F. Throw away multiple-dose vials of Retacrit no later than 21 days from the first day that you put a needle into the vial. During a review of the facility P&P titled, Storage of Medications, last reviewed 4/30/2025, the P&P indicated: Facility should assure that infusion therapy solutions not prepared by the Pharmacy provider (stock solutions) are stored in accordance with Applicable Law. Facility should assure that infusion therapy labels include the: 1) Resident name, medication name, 2) Volume, infusion rate, C. Certain medications or package types, such as IV solutions, multiple dose injectable vials . once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. During a review of the facility P&P titled, Medications - Administration, last reviewed 4/30/2025, the P&P indicated Medications are administered directly by a licensed nurse and upon the order of a physician. No medication will be used for any [resident] other than the [resident] for whom it was prescribed. Medication and biological orders will be received by a licensed Nurse prior to administration. Orders will be reviewed for allergies, food/drug interaction. Medications and treatments will be administered as prescribed to ensure compliance with dose guidelines. The licensed Nurse will verify the resident's identity before administering the medication. Based on observation, interview, and record review the facility failed to: 1. Ensure drugs were labeled in accordance with currently accepted professional principles to facilitate consideration of precautions and safe administration of medications by failing to ensure intravenous (IV - administered within a vein) ertapenem (an antibiotic [medication used to treat bacterial infections]) was labeled with the resident's name and rate of administration (the volume of fluid administered over a period of time) for one of one sampled residents (Resident 62) reviewed under the Antibiotic Use care area. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Label one (1) epoetin alfa (a generic name for Retacrit - a medication used to treat anemia [having low red blood cells]) vial for Resident 81, in accordance with manufacturer's requirements and facility policy and procedures for one (1) of three (3) inspected medication rooms (Medication Room Station 3). These deficient practices had the potential to result in residents receiving medication that had become ineffective or toxic due to improper storage or labeling, and medication administration to the wrong resident and / or at the wrong rate of administration resulting in adverse effects (an undesired and harmful result of a treatment or intervention) of medication, possibly leading to health complications, hospitalization and/or death. Findings: 1. During a review of Resident 62's admission Record (AR), the AR indicated the facility admitted the resident on 5/6/2024 and readmitted the resident on 6/2/2025, with diagnoses that included acute respiratory failure (a serious condition that occurs suddenly when the lungs cannot get enough oxygen) with hypoxia (low levels of oxygen in your body tissues), urinary tract infection (UTI - an infection in the bladder/urinary tract), and cerebral infarction (CVA -stroke, loss of blood flow to a part of the brain). During a review of Resident 62's Minimum Data Set (MDS - resident assessment tool), dated 5/14/2025, the MDS indicated the resident had the ability to understand others and had the ability to make himself understood. During a review of Resident 62's Order Summary Report, dated 6/4/2025, the Order Summary Report indicated an order for ertapenem sodium injection solution reconstituted one gram (GM - a unit of measurement), use one GM intravenously at bedtime for pneumonia (an infection/inflammation in the lungs) for three days, dated 6/2/2025. During a review of Resident 62's Baseline Care Plan (CP) regarding medications, dated 6/2/2025, the CP indicated the resident was taking an antibiotic. During a concurrent observation and interview on 6/3/2025 at 11:15 a.m. with Resident 62, Resident 62 laid in bed with an IV pole (device used for IV medication administration) with an empty vial of ertapenem taped to an empty bag of normal saline (NS - fluid used to administer IV medication). The NS bag had a label that indicated the date 6/2/2025. The label did not indicate the resident's name or the rate of administration. Resident 62 stated Resident 62 had just returned from the hospital on 6/2/2025 and the night shift nurse had administered the antibiotic to the resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/3/2025 at 11:30 a.m. with Registered Nurse (RN) 1, RN 1 entered Resident 62's room and stated the resident had just returned from the hospital and required ertapenem to treat pneumonia. RN 1 stated the pharmacy had not yet delivered Resident 62's ertapenem, so a dose was removed from the emergency medication kit (e-kit - emergency drug supplies). RN 1 stated the facility process is the nurse labels the medication from the e-kit prior to administration with the medication name, route, date and time, dose, and resident name. RN 1 stated all medication should be labeled so the administering nurse can check the medication label against a resident identifier and physician's order to ensure the right resident gets the right medication at the right rate of infusion. RN 1 assessed Resident 62's ertapenem and stated the label did not indicate the resident's name or rate of infusion. RN 1 stated when Resident 62's ertapenem was not labeled with the resident's name and rate of infusion, it could potentially result in the wrong resident receiving medication that is not intended for them. During an interview on 6/5/2025 at 6:10 a.m. with RN 2, RN 2 stated RN 2 administered Resident 62's ertapenem on 6/2/2025. RN 2 stated ertapenem is an antibiotic and antibiotics are high risk medications that must be properly labeled. RN 2 stated RN 2 removed Resident 62's ertapenem from the e-kit and RN 2 should have labeled the medication with the resident's name and rate of infusion to perform the five (5) rights of medication administration (a set of guidelines used by healthcare professionals to ensure that medications are given safely and accurately), but RN 2 did not. RN 2 stated RN 2 was in a hurry and did not label the resident's name or rate of infusion on the medication label. RN 2 stated it was important to label medication removed from the e-kit to prevent medication errors. RN 2 stated when RN 2 did not label Resident 62's ertapenem with the resident's name and rate of infusion, there was a potential to administer ertapenem to the wrong resident resulting in allergic reactions (a reaction of the immune system to a medication, often involving symptoms like hives, rash, or swelling). During an interview on 6/5/2025 at 8 a.m. with the Director of Nursing (DON), the DON stated it was important to label IV medication from the e-kit with the resident's name and rate of administration because the administering nurse needs to complete the 5 rights of medication administration to prevent medication administration errors. The DON stated RN 2 should have taken time to focus on administering Resident 62's ertapenem to prevent a medication error, but RN 2 did not. The DON stated the facility policy was not followed when Resident 62's ertapenem was not labeled with the resident's name and it could potentially result in the medication being administered to the wrong resident leading to an adverse allergic reaction or unnecessary medication administration.

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. Based on interview and record review, the facility failed to promptly provide dental services for one of one sampled resident (Resident 98) being investigated under dental services by failing to ensure: 1. Family Member (FM) 1's verbal complaint of toothache was acted upon by Social Services Director (SSD) and was referred in a timely manner and was acted upon by the Dentist. 2. SSD followed up with FM 1 if the complaint of toothache was resolved. These deficient practices had the potential to result in Resident 98 undue pain while eating that can lead to poor appetite and weight loss. Findings: During a review of Resident 98's admission Record, the admission Record indicated the facility admitted the resident on 4/13/2024, with diagnoses including dysphagia (difficulty swallowing), gastroesophageal reflux disease (GERD, a condition where stomach acid flows back up into the esophagus, causing heartburn and other symptoms), and anxiety disorder (a mental health condition where excessive worry, fear, and apprehension interfere with daily life). During a review of Resident 98's History and Physical (H&P), dated 4/15/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 98's Minimum Data Set (MDS, a resident assessment tool), dated 4/21/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a person experiences noticeable difficulty with thinking, remembering, and problem-solving, but it's not severe enough to interfere with daily life significantly). The MDS indicated the resident required maximal assistance on eating. During a review of Resident 98's Order Summary Report, dated 11/23/2024, the Order Summary Report indicated an order for dental consultation if needed (PRN) with treatment as indicated. During a review of Resident 98's Dental Record (DR) 1, dated 5/19/2025, the DR 1 indicated the resident was seen by the dentist. The DR 1 did not indicate Resident 98's chief complaint for dental referral, and the dentist wrote no pain, no swelling, oral hygiene (OHI) given, and no visible pathology (refers to the detectable signs of disease or abnormalities that can be observed with the naked eye during a medical examination, particularly when examining tissues or organs). Treatment recommendation was annual recall. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/5/2025, at 8:22 a.m., with the Social Services Director (SSD), reviewed SSD's dental referral logs, and Dental Records of residents. The SSD stated the DR 1 of Resident 98 had no chief complaint, and that the dentist had written no pain, no swelling, OHI given, and no visible pathology was documented on the residents DR 1. The SSD acknowledged that she had spoken to FM 1 regarding Resident 98's toothache three weeks ago. The DSD stated she referred the resident to the dentist and was seen on 5/19/2025. The SSD showed her dental referral logs of resident, and the name of the resident was on the chart however, there was no record of reason for referral. The DR 1 did not indicate the chief complaint of the resident, and she was not sure if the resident was seen for that reason. The SSD reviewed other residents DR, and the chief complaint was all left blank. The SSD stated she has not followed up with FM 1 regarding the complaint. The SSD stated it was important for the dentist to place the chief complaint of each resident seen on the DR to ensure the residents were seen for a specified problem. The SSD also stated she should have followed up with the FM 1 if the issue was resolved to prevent FM 1 from having to worry about Resident 98's complaint. During an interview on 6/5/2025, at 9:48 a.m., with the Director of Staff Development (DSD), the DSD stated the licensed nurses, and the social services department should have followed up with the dentist if the resident was seen for FM 1's complaint of Resident 98 having toothache. The DSD stated the SSD should have followed up with FM 1 if the resident was seen by the dentist and was aware of the recommendation of the doctor to treat the toothache of Resident 98. During an interview on 6/6/2025, at 11:14 a.m., with the Assistant Director of Nursing (ADON), the ADON stated licensed nurses should inform the Social Services Department every time a resident needed an outside services referral such as dental care. The ADON stated the SSD should have referred Resident 98 promptly to the dentist for the complaint of toothache, and ensured the resident was seen as soon as possible. The ADON stated once seen by the doctor, the SSD should have checked what the recommendations were and ensure the resident was seen for the complaint. The DR 1 of Resident 98 did not indicate the chief complaint of the resident which makes it confusing if the resident was evaluated for toothache. During a review of the facility's recent policy and procedure (P&P) titled Referrals to Outside Services, last reviewed on 4/30/2025, the P&P indicated the Director of Social Services coordinates the referral of residents to outside agencies/programs to fulfill resident needs for services not offered by the Facility. To facilitate this process, the Facility maintains service provider contracts with a variety of providers. During a review of the facility's recent P&P titled Oral Healthcare & Dental Services, last reviewed on 4/30/2025, the P&P indicated the Facility will provide oral healthcare and dental services as needed or requested by each resident. The Social Services/designee is responsible for assisting with arranging necessary dental appointments. All requests for routine and emergency dental services should be directed to the Social Services Staff/designee to ensure that appointments are made in a timely manner. Social Services will document extenuating circumstances that led to delayed referrals.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: An opened bottle brown coloring for gravy was observed with dried dark brown drippings on the side. The opened container of thickened lemon water was sticky when touched. The opened container of almond milk was sticky when touched A container of thickened apple juice did not indicate the date of when it was opened. 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 medically compromised residents who received food from the kitchen. Findings: During a brief initial kitchen observation and interview on 6/3/2025 at 7:58 a.m. with the Dietary Supervisor (DS), upon inspection of the small refrigerator in the kitchen, containers of opened thickened lemon water and almond milk were observed and were sticky when touched. The DS stated the containers of thickened lemon water and almond milk were sticky to touch. The DS stated the kitchen staff should have wiped the containers clean after each use to ensure safe and sanitary food storage. Upon further inspection of the small refrigerator, observed a container of opened apple juice and did not indicate the open date. The DS stated the container of apple juice was open and did not indicate the open date. During a concurrent observation and interview on 6/3/2025 at 8:20 a.m., inspected the opened spices and flavorings rack with the DS. Observed an opened half full container of brown coloring with dried dark brown drippings on the side. The DS stated the container was brown coloring used for the gravy and had dried dark brown drippings on the side. The DS stated the container should have been wiped by the kitchen staff after each use to keep food items in the kitchen in sanitary condition. During a follow-up interview on 6/6/2025 at 11:00 a.m. with the DS, the DS stated food items should be labeled with the date when they were opened to ensure the staff is aware when to discard a food item based on the chart that is utilized by staff in the kitchen according to manufacturer's recommendation. The DS stated if expired food items are used it had the potential for the residents to acquire food borne illnesses for residents receiving meals from the kitchen. The DS stated condiment containers and boxes of refrigerated juices and milk should wiped clean to ensure food items are stored in safe and sanitary conditions as it placed the residents at risk for food borne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/6/2025 at 12:15 p.m. with the Director of Nursing (DON), the DON stated food items in the kitchen should be labeled by the kitchen staff with the date they were opened to ensure residents are not served expired or spoiled food items as it placed them at risk for acquiring food borne illnesses from food items not stored properly in safe and sanitary conditions. The DON stated any containers of condiment or food items that are opened should be wiped clean after each use to ensure safe and sanitary food storage to prevent any food borne illnesses. During a review of the facility ' s recent policy and procedure (P&P) titled, Food Storage, last reviewed on 4/30/2025, the P&P indicated: Food items will be stored, thawed, and prepared in accordance with good sanitary practices. All items will be correctly labeled and dated. Any opened products should be placed in storage containers with tight fitting lids. Label and date all storage products.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review the facility failed to enforce its policy on storing food bought from outside or brought in by family or visitors when multiple food items including condiments were not labeled with the resident ' s name on the personal food items in the residents ' refrigerator reviewed under the kitchen task. This deficient practice placed the residents at risk for development of food-borne illnesses (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and can lead to other serious medical complications and hospitalization. Findings: During a brief initial kitchen tour and interview on 6/3/2025 at 8 a.m. with the Dietary Supervisor (DS), the DS stated the refrigerator for food brought from home, brought by visitors, or bought by residents are placed in the resident designated refrigerator in the activity room. The DS stated the refrigerator is locked and the Registered Nurse (RN) supervisor on duty has the key. The DS stated during off hours, nursing staff will get the key from the RN and will place the food items in the refrigerator and labeled with the resident ' s name and the date and will be disposed of after 48 hours. During an interview on 6/4/2025 at 6:18 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated the facility has a refrigerator for the residents in the activity room for food items brought by family or visitors. LVN 4 stated during off hours the RN has the key to the refrigerator and nursing staff are supposed to label the food items with the resident name and the date it was placed in the refrigerator and discarded after 48 hours. LVN 4 stated the activity department staff is responsible to check the expired food items as well as checking the temperature. During a concurrent observation and interview on 6/3/2025, at 6:20 a.m., in the activity room with Registered Nurse (RN) 2, while doing kitchen task inspecting patient refrigerators, observed patient refrigerator with an opened bottle of ranch dressing, 2 bottles of mayonnaise, and 1 bottle of red salsa and did not indicate the resident ' s name and the date it was opened and placed in the refrigerator. RN 2 stated the bottles of ranch, mayonnaise, and red salsa should have been dated when it was first opened, should have indicated the resident ' s name and the date it was placed in the refrigerator to ensure the food items or condiments were not expired. RN 2 stated not labeling the bottles of of ranch, mayonnaise, and red salsa with the date it was first opened could lead to resident ingesting expired or spoiled food that can cause gastrointestinal (relating to or including both stomach and intestine) symptoms such as stomachache, diarrhea, or vomiting. During a concurrent observation and interview on 6/4/2025 at 6:29 a.m. with the Director of Nursing (DON), inside the activity room during of inspection of patient refrigerator, the DON stated an opened bottle of ranch dressing, 2 bottles of mayonnaise, and 1 bottle of red salsa and did not indicate the resident ' s name and the date it was opened and placed in the refrigerator. The DON stated the staff should have placed the date, name of the patient and the time they opened the resident ' s food from home to ensure the food is not expired to prevent gastrointestinal problems brought about by ingestion of spoiled substances. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent policy and procedure (P&P) titled Food Brought in by Visitors, last reviewed on 1/18/2024, the P&P indicated the food may be brought to a resident by visitors, if the food is compatible with the resident ' s plan of care. The P&P further indicated: When food is brought into a nursing home prepared by others, the nursing home is responsible for ensuring that the food container is clearly labeled with the resident ' s name and date received and stored in a refrigerator designated for this purpose. Perishable food requiring refrigeration will be discarded after 2 hours at bedside, or if refrigerated it will then be labeled, dated, and discarded after 48 hours.

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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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain medical records in accordance with accepted professional standards and practice for two of two sampled residents (Resident 54 and 34) reviewed under the Activities care area by failing to ensure that the activity documentation was completed accurately to reflect the activity staff member who provided the activity for Resident 54 and 34. This deficient practice had the potential to result in inaccurate tracking of activity attendance and provision of care. Findings: a. During a review of Resident 54's admission Record (AR), the AR indicated the facility admitted the resident on 7/9/2021 with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 54's History and Physical (H&P), dated 3/11/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 2/24/2025, the MDS indicated the resident has the ability to understand others and makes self-understood. The MDS indicated the resident was dependent on staff with chair/bed-to-chair transfers. During a review of Resident 54's MDS, dated [DATE], the MDS indicated that participating in religious services or practices was very important to the resident while residing in the facility. During a review of Resident 54's Activity Progress Note (APN), dated 5/22/2025, the APN indicated the resident's current activity preference to participate in religious services for 1:1 visit and to continue with activity Care Plan. During a review of Resident 54's Care Plan (CP) focused on little, or no activity involvement related to physical limitations, revised 9/18/2024, the CP indicated the resident with goals of expressing satisfaction with type of activities and level of activity involvement when asked. The CP indicated interventions including to assist/escort to activity functions by activity department. During an interview on 6/5/2025 at 10:19 a.m. with the Activity Director (AD), the AD stated the Activity Assistants documents daily on the electronic charting. The AD stated they have a separate sheet that shows the residents attendance during group activities. During an interview on 6/5/2025 at 1:59 p.m. with Activities Assistant (AA) 1, AA 1 stated AAs document every day about what activities the residents do every day and if AAs do not document, it means AAs did not show their work and would not know if it was done. AA 1 stated she does not have a list of residents who attends religious service, but whoever wants to attend can attend. (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 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	During a concurrent interview and record review on 6/5/2025 at 2:08 p.m. with AA 1, Resident 54's Documentation Survey Report for Activities, from 5/1/2025 to 5/31/2025, was reviewed. AA 1 stated she is off every Sunday and Monday but on the record, it indicated she signed it. AA 1 stated she did not sign on the following dates: 5/4/2025, 5/5/2025, 5/11/2025, 5/18/2025, 5/19/2025, 5/25/2025, and 5/26/2025. b. During a review of Resident 34's AR, the AR indicated the facility originally admitted the resident on 11/10/2023 and readmitted on [DATE] with diagnoses including dementia, schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depressive type, and chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing). During a review of Resident 34's MDS, dated [DATE], the MDS indicated the resident has the ability to understand others and makes self-understood. The MDS indicated the resident required partial/moderate assistance with chair/bed-to-chair transfers. During a review of Resident 34's MDS, dated [DATE], the MDS indicated while a resident in this facility it is very important for the resident to outside to get fresh air when the weather is good. During a concurrent interview and record review on 6/5/2025 at 2:08 p.m. with AA 1, Resident 34's Documentation Record for Activities, from 5/1/2025 to 5/30/2025, were reviewed. AA 1 stated she is off every Sunday and Monday but on the record, it indicated she signed it. AA 1 stated she did not sign on the following dates 5/4/2025, 5/11/2025, 5/18/2025, 5/19/2025, 5/25/2025, and 5/26/2025. During an interview on 6/6/2025 at 1:36 p.m. with AA 2, AA 2 stated she and another activity assistant do not have access to electronic charting and has spoken to the AD about a month ago. AA 2 stated the activities department had been busy with events and that the AD was going to work on obtaining access to electronic charting. AA 2 stated she and the other activity assistant use AA 1's login for checking/charting. AA 2 stated they were supposed to have their own access so they can do their own charting and not miss any charting every day that they worked. During an interview on 6/6/2025 at 1:54 p.m. with the Director of Nursing (DON), the DON stated all facility staff are supposed to have their own access. The DON stated the purpose of having their own access is to validate that the staff were the ones who assessed the resident and for timekeeping. The DON stated it is also for compliance with labor regulations. The DON stated when facility staff is signing for others this not accurate. The DON stated there would be confidentiality risks and would not know if it is accurate and could write whatever they want. During a review of the facility's policy and procedure (P&P) titled, Activities Program, reviewed and approved on 4/30/2025, the P&P indicated that the activity care plan should be implemented for each resident and integrated into the individual interdisciplinary resident care plan. The P&P indicated activities should be available daily and maintain a current record of the type and frequency of activities provided and the names of the residents participating in each activity. The P&P indicated participation in group, independent and room visit involvement will be documented in the resident's medical record. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's P&P titled, Completion and Correction, reviewed and approved on 4/30/2025, the P&P indicated the purpose of this P&P is to ensure that medical records are complete and accurate. The P&P indicated only facility staff who are credentialed and/or have the authority to do so may document in the medical record of a resident. The P&P indicated facility staff may not sign for another person.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to designate a qualified hospice (compassionate care for people who are near the end of life) coordinator who is responsible for working with hospice representatives to coordinate care to the resident provided by the Long-term Care (LTC - ongoing medical, personal, and custodial care provided to individuals who need assistance with activities of daily living [ADLs - activities such as bathing, dressing and toileting a person performs daily] and/or have chronic health conditions) facility and hospice staff for one of one sampled resident (Resident 56) by designating the Medical Records Director (MRD) as a hospice coordinator for the facility. This deficient practice had the potential to result in a delay or lack of coordination in delivery of hospice care and services to Resident 56. Findings: During a review of Resident 56's admission Record, the admission Record indicated the facility admitted the resident on [DATE], with diagnoses including malignant neoplasm of cervix uteri (is a cancerous tumor that starts in the cells of the canal that connects the uterus to the vagina), palliative care (resident and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering), and cerebral infarction (the death of brain tissue caused by a sudden reduction or blockage of blood flow to the brain). During a review of Resident 56's History and Physical (H&P), dated [DATE], the H&P indicated the resident can make needs known but cannot make medical decisions. During a review of Resident 56's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understands others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was mostly dependent on mobility and ADLs. The MDS indicated the resident had a condition that may result in a life expectancy of less than six months and is on hospice care. During a review of Resident 56's Order Summary Report, dated [DATE], the Order Summary Report indicated an order to admit to Hospice 1 under the care of Primary Medical Doctor (PMD) 1 under routine level of care with diagnosis of malignant neoplasm of cervix and uterus. During a review of Hospice 1 Plan of Care (POC) Summary, dated [DATE], the POC indicated the resident was Do Not Resuscitate (DNR, medical document that instructs healthcare providers not to perform cardiopulmonary resuscitation [CPR] if a person's breathing or heart stops) and to admit to Hospice 1 with diagnosis of hemiplegia (a condition characterized by paralysis, or the inability to move, on one side of the body) following cerebral infarction affecting unspecified side under routine level of care and under the care of PMD 1. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 56's Care Plan (CP) Report titled, The resident has a terminal prognosis related to malignant neoplasm of cervix, vascular dementia (a form of dementia caused by impaired blood flow to the brain, leading to damage to brain tissue), and cerebrovascular accident (CVA - a medical term for a stroke), last revised on [DATE], the CP indicated an intervention to work cooperatively with the hospice team to ensure the resident's spiritual, emotional, intellectual, physical, and social needs are met. During a concurrent interview and record review on [DATE] at 11:31 a.m. with Case Manager (CM) 1, Resident 56's hospice binder was reviewed. CM 1 stated there was no Hospice POC, and there were missing signatures on the Hospice 1 Patient's Calendar from [DATE] onwards for Skilled Nurse (SN) and Hospice Aid (HA). CM 1 stated the SN and the HA were supposed to see the resident two times per week. CM 1 stated it was the responsibility of the MRD to ensure the hospice binder is complete. CM 1 stated the binder was not updated because it cannot be found. CM 1 stated the hospice binder was with the MRD. CM 1 stated he is not the hospice coordinator for the facility. CM 1 stated he and the SSD coordinate the interdisciplinary Team (IDT - a group of healthcare professionals who work together to provide comprehensive and coordinated care for residents) meeting and speaks to the family or hospice with regard to hospice care. CM 1 stated that the designated Hospice Coordinator is the MRD. During an interview on [DATE] at 9:31 a.m. with the MRD, the MRD stated that he was aware that he is the Hospice Coordinator of the facility. The MRD stated as a Hospice Coordinator, his role was to ensure the hospice medical records were complete and updated. The MRD stated his role is also summarized on the Medical Records Director Job Description. The MRD stated his background prior to becoming a Hospice Coordinator was medical billing and quality assurance in home health. The MRD stated he is not in charge of coordinating care and he is not part of the IDT. During a review of the facility-provided Job Description Manual for Health Record Coordinator, undated, the Job Description did not indicate any Hospice Coordinator role. During an interview on [DATE] at 11:14 a.m. with the Assistant Director of Nursing (ADON), the ADON stated there is no specific individual assigned as Hospice Coordinator in the facility. The ADON stated the Hospice Coordinator is the point of contact between hospice and the facility. The ADON stated the Hospice Coordinator makes sure the hospice binder is complete, residents were visited as scheduled, care plans are developed and implemented and revised as needed, coordinates IDTs, and coordinate the overall care of the residents emotionally, spiritually, mentally, and physically. The ADON stated the Hospice Coordinator should be a part of the IDT and should have clinical background to ensure high quality of care is provided to hospice residents and to avoid confusion. During a review of the facility's recent policy and procedure (P&P) titled, Hospice Care of Residents, last reviewed on [DATE], the P&P indicated hospice care may be provided for terminally ill residents when ordered by the Attending Physician and agreed to by the resident and/or surrogate decision maker. The selected hospice will be licensed in California and will have a current contract with the Facility. The Hospice and Facility will collaborate on a Care Plan for the resident. Facility and Hospice Staff will collaborate on a regular basis concerning the resident's care. All documentation concerning hospice services will be maintained in the resident's medical record.

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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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Resident 27's glass of water and desk phone were not placed on the floor beside the resident's low bed (a hospital bed designed to be closer to the floor, often with a lower height than standard hospital beds) and urinal bottle (a container used to collect urine) was labeled with the name and/or room number of the resident. 2. Mobile Linen carts A, B, C were not left open after obtaining needed linen supplies on the hallway facing the residents doors. 3. Mobile Linen carts were not covered with a loosely woven/permeable (having pores or openings that permit liquids or gases to pass through) material to protect the linens inside the cart observed during infection control task. These deficient practices had a potential to spread infections and illnesses among residents. Findings: 1. During a review of Resident 27's admission Record, the admission Record indicated the facility admitted the resident on 2/5/2018, and readmitted the resident on 7/1/2024, with diagnoses including chronic obstructive pulmonary disease (COPD - chronic lung disease causing difficulty in breathing), protein-calorie malnutrition (a condition where an individual does not consume enough protein and calories to meet their nutritional needs), and dementia (a progressive state of decline in mental abilities). During a review of Resident 27's History and Physical (H&P), dated 7/3/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 27's Minimum Data Set (MDS - a resident assessment tool), dated 5/4/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). During a review of Resident 27's Care Plan (CP) Report titled, Benign Prostatic Hypertrophy (BPH - a benign (not cancer) condition in which the prostate gland is larger than normal): At risk for urethral constriction and urinary retention, last revised on 8/26/2022, the CP indicated an intervention to monitor for signs/symptoms of urinary tract infection (UTI - infection of the urinary system). (continued on next page)

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	056380	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Feliz Healthcare & Wellness Center, LP	3002 Rowena Avenue Los Angeles, CA 90039

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/3/2025 at 10:05 a.m. with Certified Nursing Assistant (CNA) 5, inside Resident 27's room, Resident 27 laid on a low bed, with the resident's glass of water and desk phone on the floor. Resident 27's urinal bottle did not have a label with his name or room number. CNA 5 stated the glass of water and desk phone should have not been placed on the floor due to infection issue. CNA 5 stated the floor is dirty and when you place a glass of water and desk phone on the floor it gets contaminated and had a potential to cause infection to resident when the resident drinks from the glass of water and uses the phone. CNA 5 stated the facility staff were supposed to label the urinal bottle with the name and/or room number of the resident to prevent switching of urinals causing cross-contamination of infections among residents. During an interview on 6/5/2025 at 9:28 a.m. with the Director of Staff Development (DSD), the DSD stated Resident 27's glass of water and desk phone should have not been placed on the floor to prevent infection to resident. The DSD stated the urinal bottle should be labeled with the name and/or room number of the resident to ensure urinals were not used on other residents to prevent cross-contamination. During an interview on 6/6/2025 at 11:14 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the staff should have not placed Resident 27's glass of water and desk phone on the floor to prevent infection to the resident. The ADON stated Resident 27's urinal bottle should have been labeled with the name and/or room number of the resident to prevent accidental switching of the urinal that can cause cross-contamination of infection among residents. During a review of the facility's recent policy and procedure (P&P) titled Infection Control-Policies and Procedures, last reviewed on 4/30/2025, the P&P indicated the Facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Staff are trained on the infection control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. A. The depth of employee training is appropriate to the degree of direct resident contact and job responsibilities. During a review of the facility's recent P&P titled Prevention of Cross-Contamination: Resident care items, last reviewed on 4/30/2025, the P&P indicated when any personal care item is placed into service for a resident, a staff member will: a. Write the residents name and /or room number on the item; or b. Use a printed label to indicate who the item belongs to. Personal care items include, but are not limited to: c. Urinals (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 6/5/2025 at 5:29 a.m. with CNA 6, CNA 6 took supplies from Mobile Linen Cart A and left the cart open facing Resident room [ROOM NUMBER]. CNA 6 touched the clean linen gowns with personal protective equipment (PPEs - equipment worn to minimize exposure to hazards that cause serious workplace injuries and illnesses) coming from Resident room [ROOM NUMBER]. CNA 6 stated he should have not left the Mobile Linen Cart A open after getting supplies from the cart to prevent the clean linens from environmental contaminants that can get the residents sick. CNA 6 stated he should not have touched the clean linen with gloves and PPEs after providing care to residents in Resident room [ROOM NUMBER] to prevent contamination of the clean linen. During a concurrent observation and interview on 6/5/2025 at 5:36 a.m. with CNA 7, CNA 7 took supplies from Mobile Linen Cart B and left the cart open facing Resident room [ROOM NUMBER]. CNA 7 stated he should have not left the Mobile Linen Cart B open after getting supplies from the cart to prevent the clean linens from environmental contaminants that can get the residents sick. During a concurrent observation and interview on 6/5/2025 at 5:45 a.m. with CNA 8, CNA 8 took supplies from Mobile Linen Cart C and left the cart open facing Resident room [ROOM NUMBER]. CNA 8 stated he should have not left the Mobile Linen Cart C open after getting supplies from the cart to prevent the clean linens from environmental contaminants that can get the residents sick. During an interview on 6/5/2025 at 10:13 a.m. with the DSD, the DSD stated the Mobile Linen Carts should be covered at all times to prevent contamination of the clean linens to prevent infection to residents. During an interview on 6/6/2025 at 11:14 a.m. with the ADON, the ADON stated Mobile Linen Carts should be covered at all times to prevent the linens from getting contaminated in the environment that can cause illness to residents. The ADON stated after removing the needed linen supplies the staff should replace the cover right away to minimize exposure of the linens with environmental contaminants such as dirt and dust. During a review of the facility's recent P&P titled Laundry- Supply & Storage, last reviewed on 4/4/2025, the P&P indicated to ensure that all laundry on premises is supplied and stored properly. During a review of the facility's recent P&P titled Infection Control- Policies and Procedures, last reviewed on 4/30/2025, the P&P indicated the Facility's infection control policies and procedures are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. Staff are trained on the infection control policies and procedures upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. A. The depth of employee training is appropriate to the degree of direct resident responsibilities. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and resident care equipment in safe operating condition by failing to ensure the resident's bed frame control was in good repair when the control box cord had frayed and exposed wires for one of four sampled residents (Resident 25) reviewed under the Environment task. This deficient practice had the potential to place the resident at risk for injury. Cross-reference F584. Findings: During a review of Resident 25's admission Record (AR), the AR indicated the facility admitted the resident on 9/11/2021 with diagnoses that included epilepsy (chronic disorder that causes recurrent seizures [abnormal electrical activity in the brain]), cognitive communication deficit (trouble communicating because of difficulties with thinking processes, like attention, memory, or reasoning), and mood disorder (a mental health condition that primarily affects emotional state). During a review of Resident 25's Minimum Data Set (MDS - resident assessment tool), dated 3/13/2025, the MDS indicated the resident was able to understand others and was able to make themself understood. The MDS further indicated that the resident required substantial/maximal assistance from staff for bathing, dressing, personal and oral hygiene; and the resident was dependent on staff for mobility. During a review of Resident 25's Care Plan (CP) titled, Fall Prevention, initiated 11/23/2021 and last revised 9/30/2025, the CP indicated an intervention to provide the resident with a safe environment. During a concurrent observation and interview on 6/3/2025 at 10:25 a.m. with Resident 25, Resident 25 laid awake in bed while Certified Nursing Assistant (CNA) 2 was in the resident's room. CNA 2 exited the room. Resident 25 stated there were exposed wires on the bed control cord. The bed control cord had black tape partially wrapped around it with exposed wires visible. Resident 25 stated a man came and placed the tape on the bed control cord a while ago, but there remained exposed wires that were not safe. Resident 25 stated Resident 25 needed a new bed control and not just one that had just been taped. During an observation on 6/4/2025 at 10:10 a.m., Resident 25 laid awake in bed. The bed control cord had exposed frayed wires. The bed control had no black tape wrapped around the cord. During a concurrent observation and interview on 6/4/2025 at 10:15 a.m. with Resident 25 and CNA 2, CNA 2 entered Resident 25's room and stated Resident 25's bed control cord was previously repaired with tape to cover the exposed wires. CNA 2 stated on 6/4/2025 at 7:30 a.m., CNA 2 found Resident 25's bed control cord with exposed and frayed wires and no black tape. CNA 2 stated CNA 2 did not report the exposed and frayed wires because CNA 2 was busy. CNA 2 stated CNA 2 should have reported the bed control cord to maintenance right away because it was not safe for Resident 25 to have the broken bed control cord. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/4/2025 at 10:30 a.m. with the Maintenance Assistant (MA), the MA entered Resident 25's room. The MA stated it was not ok for the bed control to have exposed wires because it could be dangerous for the resident. The MA stated exposed and frayed wires on the cord should be reported right away by the staff. The MA stated the MA had previously repaired Resident 25's bed control cord by placing black tape over the exposed wires, but the MA was not aware of any other issues with Resident 25's cord. During an interview on 6/4/2025 at 2:29 p.m. with the Maintenance Director (MD), the MD stated it was not correct for the MA to repair Resident 25's bed control cord by placing electrical tape over the exposed wires. The MD stated the MA should have followed up and replaced the resident's bed if the MA could not locate a replacement bed control, but the MA did not follow up. The MD stated it was not a homelike environment for the resident to have exposed and frayed wires or black tape on the cord of the bed control. During an interview on 5/9/2025 at 9 a.m. with the Director of Nursing (DON) the DON stated any equipment or maintenance issues need to be reported immediately by staff to ensure the residents have a safe, homelike environment with everything working properly. The DON stated it is the facility policy that the maintenance department follows the equipment manuals to keep a resident's environment safe and homelike. The DON stated a homelike environment includes safety because everybody wants to feel safe in their house. The DON stated when a resident does not feel safe it may cause feelings of distress or anxiousness that can potentially affect the resident's participation in their activities of daily living. The DON stated when a resident's participation is affected it may cause a decline in the resident. The DON stated the facility's policy and procedure (P&P) and Bed Frame (BF) 1's manual was not followed when Resident 25 had exposed and frayed wires on the bed control cord. During a review of the facility P&P titled, Maintenance Service, last reviewed 4/30/2025, the P&P indicated the purpose of the P&P is to protect the health and safety of residents, visitors, and Facility Staff. The Maintenance Department maintains all areas of the building, grounds, and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the Maintenance Department may include, but are not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. During a review of the facility P&P titled, Resident Rooms and Environment, last reviewed 4/30/2025, the P&P indicated the purpose of the P&P is to provide residents with a safe, clean, comfortable and homelike environment. A review of the facility provided BF 1 manual, dated 4/1/2018, the manual indicated any cords used on or with the bed must be routed and secured properly to ensure they do not become severed during normal operation of the bed. Service and repair must only be performed by authorized service personnel. Do not operate the bed if any electrical component such as the power cord, electrical outlet, connections, motor/actuator or mechanical component has been damaged in any way. Failure to properly maintain the bed may increase risk to residents and staff.