STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056433	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, the facility failed to:1. Ensure medications were administered in a timely manner (within one hour before or one hour after scheduled time of administration) for 18 of 30 Station A residents on 4/21/2026 in Station A of the facility, as per facility's policy and procedure (P&P) titled, Medication Timing of Administration Policy, dated 2024.2. Ensure one of six sampled residents (Resident 128's) medications were administered in a timely manner (within one hour before or one hour after scheduled time of administration) on 4/21/2026 in Station A of the facility, as per facility's policy and procedure (P&P) titled, Medication Timing of Administration Policy, dated 2024.3. Ensure one of four inspected medication carts (Station A and C split Medication Cart 4) maintained accurate documentation of Resident 36's Lyrica ([generic name - pregabalin] a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat fibromyalgia [pain in muscles and soft tissues] related pain, neuropathic (nerve related) pain and a subset of seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) on accountability record or controlled medication count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances) after Lyrica was administered by Licensed Vocational Nurse (LVN) 7.These deficient practices failed to provide medications in a timely manner in accordance with physician's orders or professional standards of practice, failed to maintain accurate documentation of controlled medications, and had the potential to result in medication errors, unintended use and loss of controlled medications and adverse health consequences such as hypertension (HTN - high blood pressure), hyperglycemia (high blood glucose), inadequate pain management, seizures, stroke (loss of blood flow to a part of the brain) and hospitalization for Residents 36, 128, and 17 other facility residents. Findings:1. During the concurrent observation and interview on 4/21/2026 between 9:59 a.m. and 11:22 a.m., with LVN 2, LVN 2 prepared and administered 13 medications to Resident 128. LVN 2 stated he still needed to administer scheduled medications to 13 additional residents who were due at 9 a.m., and one resident whose medication was due at 10 a.m. LVN 2 explained that he had a twoˆhour timeframe to administer medications to 30 residents. LVN 2 stated medications scheduled for 9 a.m. were considered late if administered after 10 a.m. He stated he should have requested assistance from another licensed nurse or a nurse supervisor.During the interview on 4/21/2026 at 12:00 p.m., with Registered Nurse Supervisor (RNS) 3, RNS 3 stated LVN 2 should have reached out for assistance when he was running late with medication administration at Station A Medication Cart 1. RNS 3 stated medications should be administered within one hour before or one hour after the scheduled administration time.During the interview on 4/21/2026 at 12:42 p.m., with the Director of Nursing (DON), the DON stated the LVN may have been nervous. The DON stated if the surveyor began observing LVN 2 at 9:59 a.m., LVN 2 should have completed the 9 a.m. medication administration by 10 a.m., as nurses are allowed one hour before and one hour after the scheduled administration time. The DON stated she would inform RNS 3 to call the physician and initiate a change of condition (COC) (continued on next page)

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

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for the late administration of medications. The DON stated she could only print a report of late medication administrations after the LVN completed all medications for residents on Station A Medication Cart 1.During a review of Medication Admin Audit Report, dated 4/23/2026 and 4/21/2026, the reports indicated there were 18 residents at Station A Medication Cart 1 who received medications later than 10 a.m. on 4/21/2026.2. During a review of Resident 128's admission Record, the admission Record indicated, Resident 128 was originally admitted to facility on 2/9/2026 and readmitted on [DATE]. The admission Record indicated Resident 128 with diagnoses including but not limited to hemiplegia (total paralysis [loss of muscle function in part of the body] on one side of the body) and hemiparesis (partial muscular weakness on one side of the body) following cerebral infarction (stroke- loss of blood flow to a part of the brain) affecting left dominant side, gastrostomy ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem), seizures and cerebral infarction without residual deficits, long term (current) use of anti-thrombotic (medications that reduces formation of blood clots)/antiplatelets (medications that prevents blood cells from sticking together and forming a blood clot) and essential hypertension (high blood pressure).During a review of Resident 128's Minimum Data Set ([MDS], a resident assessment tool) dated 2/16/2026, the MDS indicated Resident 128 was rarely or never understood so there was no cognition (ability to think, understand, learn, and remember) score. The MDS indicated, Resident 128 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.During the concurrent observation and interview on 4/21/2026 between 9:59 a.m. and 11:22 a.m., LVN 2 prepared and administered 13 medications and Prostat (a protein supplement), all of which were scheduled to be administered by 10 a.m., to Resident 128 via gˆtubes. LVN 2 stated he did not have calcium carbonate carbonate (a medication used to relieve acid-reflux) 600 mg available to administer to Resident 128 during the medication pass. LVN 2 checked the resident's blood pressure using a manual blood pressure monitor and reported a reading of 132/76 millimeters of mercury (mmHg - a measurement of pressure) and heart rate was 84.a. One tablet of amlodipine (a medication used to treat HTN) 10 mg with instructions to hold for systolic blood pressure ([SBP] the pressure caused by heart while contracting) of less than 110 mmHg and pulse rate of less than 60.b. One drop of artificial tears eye drops (temporary relief for dry, irritated, or fatigued eyes) in both eyesc. One tablet of aspirin (a medication used to prevent blood clots) 81 mg chewabled. One tablet of vitamin D (a vitamin used to treat low level of vitamin D and to support immune function and muscle strength) 25 micrograms ([mcg] a unit of measurement for mass)e. 10 milliliters ([mL] a unit of measurement for volume) of docusate sodium (a medication used to treat constipation [problem with passing stool]) 50 mg/5 mLf. One-half (1/2) tablet of ezetimibe (a medication used to treat bad cholesterol) 10 mgg. 7.5 mL of ferrous sulfate (an iron supplement used to treat anemia and low level of iron) 220 mg/5 mLh. 30 mL of lactulose (a medication used to treat constipation and brain dysfunction) 10 grams ([gm] a unit of measurement for mass)/15 mLi. Five (5) mL of Keppra ([generic name - levetiracetam] a medication used to treat seizures) 100 mg/mLj. 15 mL of Elder Tonic (a supplement with vitamins B and minerals to support body functions)k. Five (5) mL of vitamin C (a vitamin used to improve immune function and treat low levels of vitamin C) 500 mg/5 mLl. 10 mL of Chlorhexidine (a disinfectant and antiseptic) 0.12% to be administered buccally (in the cheek) for oral carem. One tablet of losartan (a medication used to treat HTN) 50 mg with instructions to hold if SBP of less than 110LVN 2 was not able to swab and cleanse oral cavity with chlorhexidine rinse because Resident 128 did not open her mouth. LVN 2 stated he was supposed to dilute the Prostat with water before administering it via g-tube because the g-tube was clogging during medication administration. LVN 2 stated he needed to change the valve before resuming medication administration. LVN 2 completed administration of 13 medications and Prostat on 4/21/2026 at 11:22 a.m.During a review of Resident (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	128's Medication Admin Report, dated 4/21/2026, the Medication Admin Report indicated, Resident 128's lactulose solution, amlodipine, ferrous sulfate liquid, ezetimibe, cholecalciferol, artificial tears eye drops, losartan, docusate sodium liquid, aspirin, vitamin C liquid, levetiracetam oral solution and multivitamins liquid were administered on 4/21/2026 between 10:05 a.m. and 10:23 a.m. The Medication Admin Report indicated, the documented date and time for Resident 128's lactulose solution, amlodipine, ferrous sulfate liquid, ezetimibe, cholecalciferol, artificial tears eye drops, losartan, docusate sodium liquid, aspirin, vitamin C liquid, levetiracetam oral solution and multivitamins liquid on 4/21/2026 were at 11:27 a.m. During the interview on 4/21/2026 at 3:39 p.m., with LVN 2, LVN 2 stated Resident 128's medications were administered more than one hour late on 4/21/2026. LVN 2 stated according to facility policy, medications should be administered within one hour before or one hour after the scheduled time. LVN 2 stated administering medications late could reduce their effectiveness and place Resident 128 at risk for hypertension, elevated blood glucose, seizures, and potential hospitalization. He stated he usually completed the medication pass for 30 residents by 10:30 a.m. or 11:00 a.m., but was unsure why it took longer on 4/21/2026. LVN 2 stated administering medications to a gˆtube resident typically takes 15 to 20 minutes, and administering oral medications takes 10 to 15 minutes. Using an estimate of 15 minutes per resident, the total time needed would be 450 minutes (7.5 hours), which exceeds the required twoˆhour window for a 9 a.m. medication schedule (8 a.m. to 10 a.m.). During the interview on 4/21/2026 at 3:39 p.m., LVN 2 stated he was supposed to dilute the Prostat and stir it well before administering it via gˆtube to prevent clogging. LVN 2 stated he had to replace the gˆtube's Lopez valve (small, threeˆway stopcock device commonly used with gˆtube) because the previous valve became clogged by the Prostat. LVN 2 stated the delay in medication administration and the clogging of the gˆtube could have caused discomfort for Resident 128. During the interview on 4/23/2026 at 4:38 p.m., with the Director of Nursing (DON), the DON stated she conducted an inˆservice education for the facility nurses regarding late medication administration. The DON stated there was a risk for adverse effects when residents did not receive their medications on time.3. During a review of Resident 36's admission Record, the admission Record indicated Resident 36 was admitted to the facility on [DATE] with diagnoses that included but were not limited to other hereditary and idiopathic neuropathies (nerve pain) and other chronic pain.During a review of Resident 36's History and Physical (H&P) dated 1/21/2026, the H&P indicated Resident 36 had the capacity to understand and make decisions.During a review of Resident 36's MDS, dated [DATE], the MDS indicated Resident 36's cognition was intact. The MDS indicated Resident 36 needed setup or clean-up assistance from the facility staff for ADLs such as eating and oral hygiene, supervision assistance for upper body dressing and personal hygiene, and moderate assistance for toileting hygiene, showering, lower body dressing and putting on or taking off footwear.During a review of Resident 36's Order Summary Report, dated 4/23/2026, the Order Summary Report indicated but not limited to the following physician order: Lyrica oral capsule 75 mg (Pregabalin), give 75 mg by mouth two times a day for neuropathic pain (nerve pain), hold for lethargy (a state of severe drowsiness, sluggishness, and lack of mental or physical energy) or respiration rate (RR) less than 12, order date 3/3/2026, start date 3/3/2026.During the concurrent observation, interview, and record review on 4/23/2026 at 11:50 a.m. with LVN 7 at Station AˆC split Medication Cart 4, Resident 36's pregabalin 75 mg bubble packs for morning (a.m.) and evening (p.m.) doses, the facility's controlled medication count sheet (CDR), and the medication administration details in the electronic medical record (eMAR) were reviewed. The a.m., pregabalin bubble pack contained 21 capsules, while the CDR indicated 22 capsules remaining, with the last dose documented as administered on 4/22/2026 at 8:38 a.m. The eMAR showed the last dose of pregabalin 75 mg was documented as administered on 4/23/2026 at 8:39 a.m. The p.m., pregabalin bubble pack contained 21 capsules, while the CDR indicated 20 capsules remaining, with the last dose documented as administered on 4/23/2026 at 8:47 a.m. During the controlled medication count, when the discrepancy in the pregabalin count was identified, LVN 7 stated, I need to check blood sugars for my residents, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	you (addressing the surveyor) said it was going to be quick, my dear. Now it's taking longer for you to inspect medication cart. Can we do this after blood sugar checks.During an interview on 4/23/2026 at 1:17 p.m. with LVN 7, LVN 7 stated prior to administration of pregabalin, he was supposed to check the controlled medication book to see if the medication count was correct before taking pregabalin out of the bubble pack. LVN 7 stated he took out the pregabalin 75 mg from Resident 36's AM bubble pack but documented on the CDR for PM count sheet. LVN 7 stated he would chart or document when he was taking pregabalin out from medication bubble pack, then he would administer pregabalin, watch the resident take the medication and then he would document in the eMAR once the pregabalin was administered. LVN 7 stated it was important to maintain correct counts of controlled medications because of the associated high risk of diversion and abuse, sedation, allergic reactions and respiratory depression. LVN 7 stated there was a risk for pregabalin to be miscounted, could have led to a double dose for the resident and a medication error could occur. During the interview on 4/23/2026 at 4:58 p.m., with the Director of Nursing (DON), the DON stated for controlled medication administration, the licensed nurse should document the medication as yes in the eMAR but should not save the entry until the medication is fully administered. The DON stated the nurse should document the medication on the controlled medication count sheet as soon as it is removed from the medication card, and after administering the medication, the nurse should then save the eMAR entry as administered. The DON stated accurate documentation of controlled medications was essential to prevent misuse and drug diversion. She stated it would be important to reassess the resident for neuropathic pain or signs of exacerbation due to the pregabalin count discrepancy identified on the controlled drug record (CDR). During a review of the facility's P&P titled, Medication Timing of Administration Policy, dated 2024, the P&P indicated, 1. Standard Administration Time Frames. Routine medications shall be administered within a one-hour window before or after the scheduled time (e.g., 8:00 a.m., dose given between 7:00 a.m., and 9:00 a.m.). Critical medications shall be administered at the exact time ordered or within a more restrictive window as defined below. 2. Medications considered time-critical must be . within 60 minutes before or after the scheduled time, unless otherwise specified by the prescriber. Examples include: Insulin (rapid-acting), anticoagulants (e.g., warfarin, heparin), antibiotics with specific dosing intervals, anti-seizure medications, medications with short half-lives or requiring consistent blood levels. The P&P indicated, 5. Missed or Late Doses. If a medication is not administered within the allowable time frame: The nurse shall assess the situation.if necessary. The dose shall not be automatically .without an order, Documentation must include: Reason for delay or omission.actions taken.notifications made.During a review of the facility's P&P titled, Medication Administration, dated 2024, the P&P indicated, Medications shall be administered safely, accurately, and timely in accordance with physician orders, accepted standards of practice,.outcomes.During a review of the facility's P&P titled, Policy & Procedure: Documentation of Controlled Drugs/Medications, dated 2024, the P&P indicated, All controlled drugs/medications must be documented accurately, completely, and in a timely manner to ensure patient safety, regulatory compliance and prevention of diversion. Documentation must reflect a clear, auditable trail from receipt.disposal. The P&P indicated, 6.3 Administration Documentation. Document administration immediately after giving the medication in the Medication Administration Record (MAR/eMAR). Include: Date and time.signature/initials of administering staff. 6.4 Controlled Drug Register (CDR) Entries. Maintain a separate page.for each medication and strength. Record: running balance after each transaction. Patient details for administered doses. Staff signatures for all entries. Entries must be.(no erasing).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper storage and labeling of medications in four of four inspected medication carts (Subacute Medication Cart 1, Station C Medication Cart 3, Station A Medication Cart 1 and Station A-C split Medication Cart 4 and one of two inspected medication rooms (Station A Medication Room Refrigerator) as per manufacturer specifications and facility's policy and procedure (P&P) titled, Medication Storage and Labeling, dated 2024, Medication Labeling, dated 2024, and Medication Storage Temperature Policy, dated 2024, by failing to:1. Ensure gabapentin (a medication used to treat nerve pain and seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]) oral solutions for Residents 131 and 64 were stored in the refrigerator, as per manufacturer requirements, affecting two of four inspected medication carts (Subacute Medication Cart 1 and Station A-C split Medication Cart 4).2. Ensure Resident 74's expired insulin lispro (a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] used to treat high blood glucose [simple sugar- the body's primary source of energy from food]) was removed from medication cart, and Lantus Solostar ([generic name - insulin glargine] a long-acting insulin used to treat high blood glucose) prefilled pen was labeled with an open date, according to manufacturer requirements, stored in Station C Medication Cart 3.3. Ensure Resident 30's expired Lantus Solostar prefilled pen was removed from Station C Medication Cart 3.4. Ensure Resident 139's morphine sulfate (a controlled substance or also known as an opioid [medications that the use and possession of are controlled by the federal government] used to treat severe pain) oral solution was stored at room temperature, as per manufacturer requirements, affecting Station A Medication Cart 1 and Station A Medication Room Refrigerator.These deficient practices had the potential to result in Residents 30, 64, 74, 131 and 139 receiving medications that had become expired, ineffective or toxic due to improper storage and labeling possibly leading to adverse effects such as hyperglycemia (high blood glucose), inadequate pain management and hospitalization. Findings:1a. During a review of Resident 131's admission Record, dated 4/22/2026, the admission Record indicated Resident 131 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 131 with diagnoses including but not limited to contracture (condition of shortening or hardening leading to restricted joint mobility) of muscle, multiple sites and generalized muscle weakness.During a review of Resident 131's History and Physical (H&P) dated 8/8/2025, the H&P indicated Resident 131 did not have the capacity to understand and make decisions.During a review of Resident 131's Minimum Data Set ([MDS], a resident assessment tool) dated 3/6/2026, the MDS indicated Resident 131 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as oral hygiene, toileting hygiene, showering, upper body dressing, putting on/taking off footwear and personal hygiene, and ADLs of eating and lower body dressing were not attempted due to medical condition or safety concerns.During a review of Resident 131's Order Summary Report (a document containing a summary of all active physician orders) dated 4/22/2026, the Order Summary Report indicated but not limited to the following physician order: Gabapentin oral solution, give 100 milligrams ([mg] - metric unit of measurement, used for medication dosage and/or amount) via gastrostomy tube ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem) every eight hours for neuropathic condition resulting in burning, stabbing, or electric shock-like sensations) pain and contractures, order date 3/25/2026, start date 3/25/2026.During a concurrent observation and interview on 4/21/2026 at 3:20 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m. with Licensed Vocational Nurse (LVN) 5 of Subacute Medication Cart 1, Resident 131's gabapentin oral solution 250 mg per 5 milliliters ([mL] a unit of measurement for volume) was stored in the medication cart instead of medication refrigerator, as required by manufacturer's specifications:a. A one-fourth (1/4th) of volume of gabapentin 250 mg/5 mL remaining in bottle for Resident 131, with an open date of 3/26/2026 and pharmacy label instructions to refrigerate.According to the manufacturer's product labeling, gabapentin oral solution should be stored in refrigerator at 36-degree Fahrenheit [(F) is a unit of temperature] to 46 F or 2 Celsius [(C) is a unit of temperature] to 8 C.LVN 5 stated he took the gabapentin out of the refrigerator around 1 p.m. for a 2 p.m. dose and was going to return to the refrigerator. LVN 5 stated there was a risk that if the gabapentin was not properly stored, it would be less effective to treat nerve pain or seizures for Resident 131.1b. During a review of Resident 64's admission Record, dated 4/23/2026, the admission Record indicated Resident 64 was admitted to the facility on [DATE] with diagnoses including but not limited to other chronic pain and polyneuropathy (nerve pain).During a review of Resident 64's MDS dated [DATE], the MDS indicated Resident 64's cognition was severely impaired. The MDS indicated that Resident 64 was dependent on facility's staff for performing ADLs such as eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing and personal hygiene, and putting on/taking off footwear was not attempted due to medical condition or safety concerns.During a review of Resident 64's Order Summary Report, dated 4/5/2026, the Order Summary Report indicated but not limited to the following physician order: Gabapentin oral solution 250 mg/5 mL, give 100 mg by mouth two times a day for neuropathic pain, give 2 mL = 100 mg, order date 9/22/2025, start date 9/22/2025.During a concurrent observation and interview on 4/23/2026 at 11:50 a.m. with LVN 7 of Station A-C split Medication Cart 4, Resident 64's gabapentin oral solution 250 mg/5 mL was stored in medication cart instead of medication refrigerator, as required by manufacturer's specifications:a. Less than 1/4th volume of gabapentin 250 mg/5 mL remaining in the bottle for Resident 64 with an open date of 3/28/2026 and pharmacy label instructions to refrigerate.According to the manufacturer's product labeling, gabapentin oral solution should be stored in refrigerator at 36 F to 46 F or 2 C to 8 C.LVN 7 stated he could not remember how long it had been since he (LVN 7) removed gabapentin oral solution from the refrigerator and stored in the medication cart. LVN 7 stated gabapentin oral solution should have been stored in the refrigerator. LVN 7 stated gabapentin had been in the medication cart possibly for three and half hours since it was removed from the refrigerator. LVN 7 due to medication's improper storage, there could be instability, reduced efficacy or could become ineffective. LVN 7 stated gabapentin oral solution might not work for Resident 64 who was using it to treat neuropathic pain and thought the side effects could be drowsiness and possible respiratory depression.2. During a review of Resident 74's admission Record, dated 4/22/2026, the admission Record indicated Resident 74 was admitted to the facility on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood glucose).During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74's cognition was intact. The MDS indicated Resident 74 needed supervision assistance from the facility staff for ADLs such as eating, moderate assistance for oral hygiene, upper body dressing and personal hygiene, maximal assistance for showering and lower body dressing, and dependent for toileting hygiene and putting on/taking off footwear.During a review of Resident 74's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated but not limited to following physician orders: Insulin Glargine subcutaneous (under the skin) solution 100 units/mL, inject 20 units subcutaneously at bedtime for DM, hold for blood sugar (BS) less than (<) 100. If BS <70 mg/dL, may give apple juice if BS <70 if able to swallow. Repeat BS check in 15 minutes, and notify MD. Rotate the sites, order date 3/1/2026, start date 3/1/2026. Insulin Lispro injection solution 100 units/mL, inject as per sliding scale: if 70-150 = 0; 151-200 = 2; 201-250 = 4; 251-300 = 6; 301-350 = 8; 351-400 = 10; great than (>) 400, give 12 units and call MD, subcutaneously before meals and at bedtime for DM, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	may give apple juice if BS <70 if able to swallow. Repeat BS check in 15 minutes and notify MD. Rotate sites, order date 1/28/2026, start date 1/29/2026.During a concurrent observation and interview on 4/22/2026 at 1:14 p.m. with LVN 1 of Station C Medication Cart 3, the following insulins were either found expired and not discarded and/or not labeled, as required by manufacturer's specifications:a. One opened prefilled pen of insulin lispro 100 units/mL for Resident 74 with an open date of 3/22/2026 and an expiration date of 4/20/2026.According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature, below 86 F (30 C), insulin lispro pen must be used within 28 days or be discarded.b. One prefilled pen of Lantus Solostar 100 units/mL for Resident 74 with no open date.According to the manufacturer's product labeling, unopened / not in-use pen if stored at room temperature (a below 86 F [30 C]) and opened / in-use pen must be used within 28 days.LVN 1 stated the expired insulin for Resident 74 should have been removed on 4/20/26. LVN 1 stated the insulin might not be safe and effective for the resident. LVN 1 stated the insulin might not treat high blood glucose levels and Resident 74 could have an adverse reaction to the medication.During a review of Resident 74's Medication Administration Record (MAR), dated 4/20/2026 to 4/22/2026, the MAR indicated Resident 74 potentially received the expired insulin lispro six times.3. During a review of Resident 30's admission Record, dated 4/22/2026, the admission Record indicated Resident 30 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including but not limited to Type 2 Diabetes Mellitus without complications.During a review of Resident 30's MDS dated [DATE], the MDS indicated Resident 30's cognition was moderately impaired. The MDS indicated Resident 30 needed moderate assistance from the facility staff for ADLs such as eating, maximal assistance for oral hygiene, upper body dressing, lower body dressing and personal hygiene, and dependent for toileting hygiene, showering and putting on/taking off footwear.During a review of Resident 30's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated the following physician order: Insulin Glargine subcutaneous solution 100 units/mL, inject five (5) units subcutaneously one time a day for DM. Finger stick blood sugar (FSBS) every morning. Hold if FSBS <100 mg/dL. May give apple juice if BS <70 if able to swallow. Repeat blood sugar (BS) check in 15 min and notify MD. Rotate sites, order date 11/14/2025, start date 11/15/2025.During a concurrent observation and interview on 4/22/2026 at 1:14 p.m. with LVN 1 of Station C Medication Cart 3, the following insulin expired and was not discarded as required by manufacturer's specifications:a. One prefilled pen of Lantus Solostar 100 units/mL for Resident 30 with an open date of 3/22/2026 and an expiration date of 4/20/2026.According to the manufacturer's product labeling, unopened / not in-use pen if stored at room temperature (a below 86 F [30 C]) and opened / in-use pen must be used within 28 days.LVN 1 stated the expired insulin for Resident 30 should have been removed on 4/20/26. LVN 1 stated the insulin might not be safe and effective for the resident. LVN 1 stated the insulin might not treat high blood glucose levels and Resident 30 could have an adverse reaction to the medication.During a review of Resident 30's MAR, dated 4/20/2026 to 4/22/2026, the MAR indicated Resident 30 potentially received the expired Lantus Solostar (generic name - insulin glargine) two times.4. During a concurrent inspection and interview on 4/22/2026 at 3:46 p.m. with LVN 6 of Station A Medication Cart 1 and Station A Medication Room Refrigerator, Resident 139's unopened or sealed bottle of morphine sulfate 100 mg/5 mL oral solution was found in Station A Medication Room Refrigerator, which was not in accordance with manufacturer's specifications.According to the manufacturer's product labeling, morphine sulfate oral solution should be stored at controlled room temperature, 15 C to 30 C (59 F to 86 F).LVN 6 stated, Resident 139's morphine sulfate oral solution was supposed to be stored at room temperature but was found in the refrigerator, which was against the manufacturer's specifications and requirements, even the package indicated to store at room temperature. LVN 6 stated the medication would not be safe or effective to administer to resident.During an interview on 4/23/2026 at 5:11 p.m. with the Director of Nursing (DON), the DON stated there was as risk of affecting gabapentin oral solution's integrity, stability and it could become less potent. The DON stated there was a risk that residents could possibly not be (continued on next page)

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Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	managed well with neuropathic pain and residents could continue to be in pain, which would lead to less participation in activities and would also negatively affect their mood.During an interview on 4/23/2026 at 5:11 p.m. with the DON, the DON stated the insulins should be discarded 28 days after their open date. The DON stated there was a risk that insulins that expired on 4/20/2026 would not be effective if administered to residents and could increase the risk for hyperglycemia and hospitalization.During an interview on 4/23/2026 at 5:16 p.m. with the DON, the DON stated the facility nurse should have verified with the pharmacy if they did not know how to store morphine sulfate oral solution. The DON stated the pharmacy informed her (DON) that morphine could become too thick and might not be a comfortable consistency to administer to the resident when it was stored in refrigerator instead of at room temperature.During a review of the facility's P&P titled, Medication Storage Temperature Policy, dated 2024, the P&P indicated, To ensure all medications are stored under proper temperature conditions to maintain safety, stability, and effectiveness in compliance with regulatory requirements. The P&P indicated, Room Temperature Requirements. Medications labeled for controlled room temperature shall be stored between 68 F-77 F (20 C-25 C). Manufacturer's labeling instructions shall always take precedence over standard ranges. 2. Refrigerator Temperature Requirements. Medications requiring refrigeration shall be stored between 36 F-46 F (2 C-8 C).During a review of the facility's P&P titled, Medication Storage and Labeling, dated 2024, the P&P indicated, All medications shall be.with physician orders, manufacturer instructions and regulatory requirements. Medications must be maintained to ensure integrity, safety.personnel. The P&P indicated, This policy means that medications must be: Properly labeled.Stored under appropriate conditions.Protected from contamination.unauthorized access. The P&P indicated, Staff are expected to: Check for: Expired medications.Ensure multi-dose containers are dated when opened (if applicable). The P&P indicated, To implement this policy.remove and properly dispose of: Expired medications, discontinued medications.During a review of the facility's P&P titled, Medication Labeling, dated 2024, the P&P indicated, Insulin. Multi-dose vials or pens must be dated when opened, Discard per manufacturer guidelines.

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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 follow and observe infection control measures for five of 30 sampled residents. The facility failed to:a. Ensure padded side rails that were wrapped with porous (having minute spaces or holes through which liquid or air may pass) foams were disinfected properly for Resident 4 and Resident 37. b. Ensure Resident 39's peripheral intravenous catheter (PIV- small flexible tube inserted into a peripheral vein-usually in the hand or arm to deliver fluids or medications) was discontinued when it was no longer needed and intravenous antibiotic (medication to treat an infection is delivered directly into the bloodstream through a vein) was completed. c. Ensure Certified Nursing Assistant (CNA) 7 practiced hand hygiene before entering Resident 148's room and before donning a pair of gloves. d. Ensure Resident 44's urinary catheter drainage bag was not placed on the floor.These failures had the potential to increase the risk of cross-contamination (the transfer of bacteria, viruses, microorganisms or other harmful substances from one surface to another through improper or unsanitary equipment, procedures, or products) and spreading infection among the residents, staff and visitors.Findings: a. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. The admission Record indicated Resident 4 with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), dependence on respirator (ventilator- a machine for artificial breathing), and atrial fibrillation (irregular heart rate that can cause poor blood flow). During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 4's cognitive (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 4 was dependent on staff with oral hygiene, toileting hygiene, showering, and personal hygiene. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 37 with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), encephalopathy (any damage or disease that affects the brain), and sepsis (life-threatening blood infection). During a review of Resident 37's History and Physical (H&P), dated 1/3/2026, the H&P indicated, Resident 37 did not have the ability to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 37's cognitive (ability to think, understand, learn, and remember) skills for daily decision making were severely impaired. The MDS indicated Resident 37 was dependent (helper does all the effort, or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff with oral hygiene, toileting hygiene, showering, personal hygiene, and rolling left and right. During an observation on 4/21/2026 at 10:06 a.m. in Resident 4's room, the resident's side rails were observed padded with foam and secured with electrical tape (a pressure-sensitive and non-conductive tape). During an observation on 4/21/2026 at 10:21 a.m. in Resident 37's room, the resident's side rails were (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed padded with foam and secured with electrical tape. During an interview on 4/22/2026 at 11:32 a.m. with Housekeeping Staff (HKS) 1, HKS 1 stated she cleans the side rails wrapped with porous foams using disinfectants identified as 730 solution and Super Sany-Cloth. HKS 1 stated she cleaned all equipment, including the foam-wrapped side rails, using the disinfectants. During a concurrent interview and record review on 4/23/2026 at 11:15 a.m. with the Infection Preventionist Nurse (IPN), manufacturer's guidelines for Super Sani-Cloth and 730 HP disinfect Cleaner, both undated, were reviewed. The IPN stated both products designed for nonporous surfaces. The IPN stated using the disinfectants on the porous foam was not appropriate because they were porous and could cause the surface not to be cleaned properly and break down the foam. IPN stated, this practice would place vulnerable residents including Resident 4 and 37 at risk for infection. During a review of the facility 's policy and procedure (P&P) titled, Cleaning and Disinfection of Environmental Surfaces, dated 2024, the P&P indicated, staff should ensure a clean, safe, and sanitary environment through standardized housekeeping practices that reduce the risk of infection transmission, for porous materials (foam or exposed surfaces) staff should: 1.Clean per manufacturer instructions for use (IFU) 2.Do not rely on disinfectant wipes for disinfection During a review of the manufacturer's guideline titled, 730 HP Disinfectant Cleaner, undated, the guideline indicated the cleaner is a one-step hospital-use germicidal disinfectant cleaner and deodorant designed for non-porous surfaces. During a review of the manufacturer's guideline titled, Super Sani-Cloth, undated, the guideline indicated the wipe is designed to be compatible with hard non-porous surfaces. b. During a review of Resident 39's admission Record, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including pneumonia (infection/inflammation in the lungs), urinary tract infection (UTI- an infection in the bladder/urinary tract) and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 39's Minimum Data Set (MDS- a resident assessment tool) dated 3/10/2026, the MDS indicated Resident 39 had an intact cognition (ability to think, understand, learn, and remember) and required substantial/ maximal assistance (helper does more than half the effort) with bed mobility, transfer to and from a bed to a chair. During a review of Resident 39's Order Summary Report dated 4/9/2026 indicated an order of Ertapenem Sodium (antibiotic- medication to treat infection) 500 milligrams (mgs. - unit of measurement) intravenously (through the vein) one time a day for UTI until 4/16/2027 11:59 p.m. for 7 days. During a review of Resident 39's Order Summary Report dated 4/10/2026 at 9:06 a.m. indicated an order to extend peripheral line (PIV) more than 3 days and one time only until 4/16/2026. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 39's Medication Administration Record (MAR) for the month of April 2026, the MAR indicated Resident 39 received Ertapenem from 4/9/2026, 4/10/2026, 4/11/2026, 4/12/2026, 4/13/2026, 4/14/2026, 4/15/2026 and 4/16/2026. During a concurrent observation and interview on 4/21/2026 at 10:42 a.m. in Resident 39's room, Resident 39 was sitting in her wheelchair. Observed a peripheral catheter on her right hand labeled with a date of 4/9/2026 and initial of a staff. Resident 39 stated she was not receiving any medication or fluids that will need the use of PIV. Resident 39 stated she did not know why she still has the PIV catheter on her right hand. During a subsequent observation and interview on 4/22/2026 at 4:33 p.m. with Resident 39, Resident 39 stated a staff removed the PIV this morning. Observed a small area of redness on the area of the right hand where the PIV was inserted. During a concurrent interview and record review on 4/23/2026 at 11:57 a.m. with Registered Nurse Supervisor (RNS) 3, Resident 39's MAR and Order Summary Report were reviewed. RNS 3 stated Resident 39 's last dose of Ertapenem was 4/16/2026. RNS 3 stated the facility should discontinue the PIV after last dose of antibiotic or intravenous fluids (IVF-sterile liquids injected directly into a vein to treat dehydration or deliver medications). RNS 3 stated she forgot to remove the PIV and it should have been removed on 4/16/2026 after the last dose of Ertapenem. RNS 3 stated not removing PIV when it is no longer necessary can put the resident at risk for infection on the PIV site (area). During an interview on 4/24/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated peripheral IV catheter should be removed if it is no longer needed by the resident because Resident 39 can develop infection on the PIV site or at risk for developing phlebitis (inflammation of a vein near the surface of the skin). During a review of facility's policy and procedure (P&P) titled, Peripheral IV Line Care and Removal, dated 2024, the P&P indicated all licensed nursing staff will provide care, maintenance, and removal of peripheral IV lines in accordance with the physician orders with the goal of minimizing complications such as infection, infiltration, and phlebitis. c. During a review of Resident 148's admission Record, the admission Record indicated Resident 148 was originally admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses including nontraumatic subdural hemorrhage(spontaneous, slow bleeding under the skull that creates a bruise without a fall or hit), gastrostomy(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems),unspecified dementia(a progressive state of decline in mental abilities), and hyperlipidemia(high level of fats in the blood). During a review of Resident 148's History and Physical (H&P) dated 1/6/2026, the H&P indicated Resident 148 did not have decision making capacity. During a review of Resident 148's MDS dated [DATE], the MDS indicated the resident was dependent (helper does all the effort to complete the activity) on staff with oral hygiene, bathing, toileting hygiene, dressing, and personal hygiene. During a concurrent observation and interview on 4/21/2026 at 9:30 a.m. in Resident 148's room, Certified Nursing Assistant (CNA) 7 entered Resident 148's room then donned (put on) a pair of gloves (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	without practicing hand hygiene. CNA 7 stated he forgot to practice hand hygiene before putting on a pair of gloves. CNA 7 stated practicing hand hygiene before entering a resident's room is a way to keep his hands clean. During an interview on 4/24/2026 at 11:18 a.m. with RNS 4, RNS 4 stated hand hygiene should be performed before entering a resident's room and before putting on a pair of gloves. RNS 4 stated hand hygiene is a standard practice for infection control and can prevent spread of infection. During an interview on 4/24/2026 at 12:56 p.m. with Infection Preventionist Nurse (IPN), IPN stated hand hygiene should be practiced before donning a pair of gloves to prevent spread of infection. During an interview on 4/24/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated staff should practice hand hygiene before and after going to a resident's room. The DON agreed using gloves is not a replacement for hand hygiene. The DON stated staff not practicing hand hygiene can spread infection among the residents and staff. During a review of facility's policy and procedure (P&P) titled, Handwashing/ Hand Hygiene, the P&P indicated the use of gloves does not replace handwashing or hand hygiene and staff will perform hand hygiene before applying non-sterile gloves. The P&P indicated hand hygiene is considered the primary means to prevent spread of infection in the facility. d.During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 44 with diagnoses including end stage renal disease (ESRD – permanent kidney function loss)congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), dependence on renal dialysis (a treatment to cleanse the blood of waste and extra fluids artificially through a machine when the kidneys have failed) and diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 44's Care Plan titled Suprapubic Catheter (a thin, flexible tube inserted through a small incision in the lower abdomen into the bladder to drain urine) Indwelling foley catheter with risk of urinary tract infection (UTI -infection in the bladder/urinary tract).dated 7/24/2025, the Care Plan interventions indicated for leg anchor (device, that holds the catheter tubing firmly to your leg). During a review of Resident 44's Care Plan titled Risk for infection and backflow related to improper positioning of urinary bag due to resident's noncompliance, dated 11/3/2025, the Care plan goal indicated resident will maintain proper urinary drainage bag placement to prevent infection or backflow The Care Plan interventions indicated to document education resident's response and compliance or refusal. During a review of Resident 44's History and Physical (H&P) dated 3/1/2026, the H&P indicated, Resident 44 had the capacity to consent, however with mild cognitive (ability to think, understand, learn, and remember) impairment. During a concurrent observation and interview on 4/22/2026 at 7:50 a.m. with Certified Nurse Assistant (CNA) 8, Resident 44's suprapubic catheter drainage bag was observed on the floor. CNA 8 acknowledged that Resident 44's drainage bag was on the floor and should be secured on the bed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	frame. CNA 8 stated that all of the nursing staff are responsible for ensuring that infection control was maintained for resident's with indwelling devices such as a suprapubic catheter. CNA 8 stated that Resident 44 could get an infection, and have to be hospitalized if proper infection control practices were not followed. During a concurrent observation and interview on 4/22/2026 at 7:55 a.m. with License Vocational Nurse (LVN) 4, Resident 44's suprapubic drainage bag observed on the floor. LVN 4 acknowledged that the resident's drainage bag was on the floor. LVN 4 stated that she was responsible for ensuring that the resident's drainage bags were covered, and positioned on the bed frame to prevent any infections and protect the resident's privacy. LVN 4 stated that by the drainage bag being on the floor it increases the risk of contamination and infection, including urinary tract infection, and risk of cross-contamination (transfer of harmful germs) from environmental pathogens (germs that live, grow, and survive in the natural environment). During an interview on 4/24/2026 at 3:00 pm with the Director of Nursing (DON), the DON stated the drainage bag should always be kept off the floor and below the bladder to prevent backflow and reduce the risk of infection. The DON stated that the drainage bag should be secured to the bed frame. The DON stated that if there is an order for a leg anchor the catheter tubing should be secured to the resident's leg to prevent pulling, trauma, and movement of the catheter. The DON stated that this also helps to maintain proper positioning of the drainage bag. The DON stated that the drainage bag lying directly on the floor and the catheter not secured with a leg anchor, was not acceptable and was not consistent with the facility's standard of care. The DON stated that this could increase the risk of infection, including urinary tract infections, and could also lead to catheter dislodgement or trauma due to lack of securement. During a review of the facility's policy and procedure (P&P) titled, Suprapubic Catheter Management dated 2024, the P&P indicated The facility ensures safe, sterile, and effective management of suprapubic catheters (SPCs) to reduce the risk of infection, maintain urinary drainage, and promote patient comfort and dignity.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 10's) Seroquel ([generic name - quetiapine], a medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) was prescribed and administered in accordance with an appropriate clinical indication and diagnosis.This deficient practice had the potential to expose Resident 10 to unnecessary medication and to significant adverse consequences (unwanted, uncomfortable, or dangerous drug effects) resulting from the prolonged use of Seroquel for mental health condition. Such consequences could lead to impairment or a decline in the resident's mental, physical, functional, or psychosocial status.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 10 with diagnoses including but not limited to unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, generalized anxiety disorder (a condition where someone worries constantly about everyday issues and situations), recurrent major depressive disorder (sadness, low mood).During a review of Resident 10's Psychiatry (branch of medicine focused on diagnosis, treatment and prevention of mental disorders) note, dated 7/1/2025, the Note indicated, Psych consult requested for med/behavior review.On trazodone (a medication used to treat depression) 50 mg.every hour of sleep (hs-daily at bedtime) for insomnia (difficulty falling and staying asleep). No other psych meds. Following admission.patient was agitated and restless.No other major behavioral issues reported. Sleep good. Dx (diagnoses): Alcohol (ETOH) use disorder, ETOH induced sleep disorder, unspecified insomnia disorder.During a review of Resident 10's Medication Regiment Review (MRR - a monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) dated 1/29/2026, the review indicated the following note from the consultant pharmacist, Resident 10: MRR date 1/22/2026: Clarify for diagnosis and appropriate behavior. Seroquel oral tablet 25 mg (Quetiapine fumarate), give 25 mg by mouth two times a day for agitation. There was no follow-through notes documented.During a review of Resident 10's MRR dated 2/27/2026, the review indicated the following note from the consultant pharmacist, Resident 10: Seroquel oral tablet 50 mg (Quetiapine fumarate) give one tablet by mouth two times a day for agitation manifested by (m/b) tries to jump out of the bed, *Note to follow up (f/u) with doctor to clarify underlying diagnosis. Please f/u to evaluate monitoring of all indicated behavior(s) and potential side-effect(s) for Quetiapine on the Medication Administration Record. The follow-through indicated, Dementia with behavioral disturbances.During a review of Resident 10's Physician's Note titled, Nursing Home Visit dated 3/23/2026, electronically signed by physician at 4/23/2026 at 10:08 p.m., the document indicated, Subjective: follow up visit in person. Meds reviewed. Staff consulted. Since last visit, Seroquel and prn Ativan ([generic name: lorazepam] a medication used to treat anxiety) added. Patient is still restless manifested by wheeling around facility but less agitated since Seroquel added. Verbalizations are repetitive. No current difficulty with sleep. No side effects reported. Assessment: Improved from last visit. Diagnosis: ETOH (alcohol) use disorder, Unspecified sleep disorder, Unspecified mood disorder. Plan: Change indication for Seroquel to Mood Instability m/b agitated outbursts.During a review of Resident 10's Minimum Data Set (MDS resident assessment tool), dated 3/24/2026, the MDS did not indicate a cognition (ability to think, understand, learn, and remember) score. The MDS indicated Resident 10 needed maximal assistance from facility for Activities of Daily Living (ADLs) such as eating, oral hygiene, upper body dressing and personal (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene, and was dependent on facility staff for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS indicated diagnoses for Resident 10 were not-Alzheimer's, dementia, anxiety disorder and depression.During a review of Resident 10's MRR dated 3/29/2026, the review indicated the following note from the consultant pharmacist: Resident 10: Seroquel oral tablet 50 mg (Quetiapine fumarate) give one tablet by mouth two times a day for mood instability m/b agitated outburst, Note to follow up (f/u) with doctor to clarify underlying diagnosis. There were no follow-through notes documented.During a review of Resident 10's Order Summary Report , dated 4/5/2026, the Order Summary Report indicated but not limited to the following physician orders: Seroquel oral tablet 50 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for mood instability manifested by (m/b) agitated outburst, non-pharmacological intervention (NPI): 1 = Re-assurance, 2 = Redirection, 3 = Relaxation technique, 4 = calming environment, 5 = gentle massage, 6 = Meaningful activities, 7 = Other, order date 3/23/2026, start date 3/24/2026.The facility did not provide Resident 10's active orders as of 4/22/2026 and/or 4/23/2026 as per request. During a review of Resident 10's MAR dated 4/1/2026 to 4/22/2026, the MAR indicated Seroquel oral tablet 50 mg was administered 44 times to Resident 10.During a review of Resident 10's MAR dated 3/1/2026 to 3/31/2026, the MAR indicated Seroquel oral tablet 50 mg was administered 48 times to Resident 10.During a review of Resident 10's MAR dated 2/1/2026 to 2/28/2026, the MAR indicated Seroquel oral tablet 25 mg was administered 51 times to Resident 10.During a concurrent interview and record review on 4/23/2026 at 3:29 p.m. with Licensed Vocational Nurse (LVN) 6, Resident 10's electronic medical records and physical chart notes were reviewed. LVN 6 stated Resident 10 was on Seroquel for angry outbursts related to agitation and episodes of wandering (walk around without any clear purpose or direction) at times and screaming. LVN 6 stated Resident 10 should have been evaluated by a psychiatrist for his illnesses. LVN 6 stated she could not find any psychiatrist notes.During the interview on 4/23/2026 at 5:19 p.m., with the Director of Nursing (DON), the DON stated after the consultant pharmacist submitted MRR recommendations, the DON reviewed them as soon as the following day and attempted to address them before the next review date. The DON stated difficulty reviewing the volume of material, noting there were 600 pages and not enough time to review them all. The DON stated residents were routinely seen by a psychiatrist at least quarterly. The DON stated the psychiatric consult had not been uploaded into the facility's electronic health record system, but confirmed that a consult existed and would need to be located. When asked about Resident 10, the DON stated they had requested the psychiatrist to see the resident. The DON added that if a resident's medication list did not contain the correct diagnosis, they would ask the physician to reevaluate.During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Management Policy, dated 2024, the P&P indicated, To ensure the safe, appropriate, and clinically justified use of psychotropic medications while protecting residents from unnecessary drugs, adverse effects, and chemical restraint. Psychotropic medications shall be used only when clinically indicated, prescribed in accordance with accepted standards of practice, and monitored.safety. The P&P indicated, General Requirements: Each psychotropic medication must have: a documented clinical indication/diagnosis .Ongoing evaluation of effectiveness. Medications shall not be used for staff convenience or discipline.During a review of the facility's P&P titled, Medication Regimen Review (MRR) Policy, dated 2024, the P&P indicated, Scope of Review: the MRR shall include, but is not limited to: Medication appropriateness (indication, dose, duration). The P&P indicated, Physician Response: The attending physician must: Review and respond to reported irregularities; Indicate agreement, disagreement or alternative action; Responses must be documented in the medical record.Cross reference F756

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately assess the oral and dental status on the Minimum Data Set (MDS) for one of five sampled residents (Resident 26).This failure had the potential to result in Resident 26 not receiving necessary oral care and treatment.Findings:During a review of Resident 26's admission Record, the admission Record indicated Resident 26 was admitted to the facility on [DATE] to with diagnoses including diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), schizoaffective disorder, (a mental illness that can affect thoughts, mood, and behavior) , depression(serious mood disorder characterized by persistent sadness, loss of interest and low energy) and hypertension(HTN-high blood pressure).During a review of Resident 26's Dietary assessment dated [DATE], the Dietary Assessment indicated Resident 26 was edentulous (a person has lost all or some of their natural teeth) and had no difficulty in chewing and swallowing food.During a review of Resident 26's Minimum Data Set (MDS- a resident assessment tool) dated 3/7/2026, the MDS indicated Resident 26 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 26 required setup or clean-up assistance with oral hygiene, dressing and personal hygiene. The MDS indicated Resident 26 had natural teeth.During a review of Resident 26's Care Plan titled, Dental Care, initiated on 4/23/2026, the Care Plan indicated Resident 26 is edentulous and at risk for inadequate nutrition and alteration in comfort. The Care Plan's interventions included notifying the physician about pain issues and monitoring food intake, appetite and weight.During a concurrent observation and interview on 4/21/2026 at 3:28 p.m. with Resident 26, Resident 26 had no natural teeth. Resident 26 stated she did not like dentures because they hurt and would like to have dental implants.During a concurrent interview and record review on 4/23/2026 at 8:46 a.m. with Minimum Data Set Nurse (MDSN) 1, Resident 26's MDS assessment dated [DATE] and Dietary assessment dated [DATE] were reviewed. MDSN 1 stated MDS assessment was not coded correctly regarding Resident 26's oral (mouth) and dental (referring to teeth and oral care) status. MDSN 1 stated accurate assessment of Resident 26's dental status is important because it can affect the care of the resident by not providing the right level of care.During an interview on 4/24/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated accurate assessment will ensure appropriate plan of care will be implemented for the resident. The DON stated care plan for the resident will be affected if the MDS assessment is inaccurate.During a review of facility's policy and procedure (P&P) titled, Policy on Accurate Assessment- Minimum Data Set, dated 2024, the P&P indicated MDS assessments should reflect resident's actual condition, supported by clinical documentation in the medical record, completed within time frames and false, misleading and unsupported documentation is strictly prohibited. The P&P indicated MDS Coordinator will review assessments for accuracy and completeness.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility documentation, and staff interview, the facility failed to ensure timely follow-up and coordination of a require Preadmission Screening and Resident Review (PASRR) Level II evaluation for one of four sampled residents (Resident 14) identified through PASRR Level I screening as needing further evaluation for Serious Mental Illness (SMI).This deficient practice placing the Resident 14 at risk for unmet mental health needs and noncompliance with federal PASRR requirements of competition of level II by the facility.Findings:During a review of Resident 's admission Record, the admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included paranoid schizoaffective (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest), and anxiety disorder (excessive, persistent, and uncontrollable fear, worry, or dread that interferes with daily life).During a review of Resident 14's Minimum Data Set ([MDS] - a resident assessment tool), dated 1/26/2026, the MDS indicated, Resident 14 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated, Resident 14 required maximal assistance (helper does more than half the effort) from staff with eating, oral hygiene, and upper body dressing.During a concurrent interview and record review on 4/24/2026 at 12:43 p.m. with Minimum Data Set Nurse 1(MDSN 1), Preadmission Screening and Resident Review (PASRR) level I screening dated 05/02/2025 was reviewed. The form indicated SMI level II Mental Health Evaluation was required. Notice of Evaluation for Level II screening completion dated 05/07/2025 indicate level II assessment was not completed due to facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the Level II screening. As a result of the facility's lack of response, the PASRR Level II case was subsequently closed without completion of the required evaluation.MDSN1 stated the PASRR Level I screening for Resident 14, dated 05/02/2025, showed a positive result for Serious Mental Illness (SMI), which required a PASRR Level II mental health evaluation prior to or upon admission in accordance with federal regulations. MDSN 1 stated the facility failed to follow up on the PASRR Level II because no staff member took ownership of the task; responsibility fell between the nurses and medical records staff, and the process was overlooked. MDSN1 stated that moving forward, the facility will establish a process to prevent this issue from recurring.During an interview, on 4/24/2026 at 2:28 pm with the Director of Nursing (DON), the DON stated residents identified through PASRR Level I screening as requiring Level II evaluation must receive timely follow-up to ensure compliance and appropriate care planning. The DON stated failure to respond to PASRR communications may result in delays or failure to complete required evaluations. The DON stated moving forward, she will have a process of assigning certain staff for PASSR.During a Review of facility's policy and procedure titled Preadmission Screening and Resident Review (PASRR) undated indicated Referral :if the level I screen is positive for SMI or (intellectual Disability) ID referral is made to the State Mental Health or Intellectual Disability Authority.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement comprehensive processing center care plan for Resident 14 identified through PASSR level 1 screening as requiring level II evaluation for residents 14.This deficient practice placed the residents at risk for unmet needs and lack of appropriate coordination of care and services.Findings:During a review of Resident 's admission Record, the admission Record indicated, Resident 14 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 14's diagnoses included paranoid schizoaffective (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes persistent feeling of sadness and loss of interest), and anxiety disorder (excessive, persistent, and uncontrollable fear, worry, or dread that interferes with daily life).During a review of Resident 14's Minimum Data Set ([MDS] a resident assessment tool), dated 1/26/2026, the MDS indicated, Resident 14 had moderate cognitive (ability to think, understand, learn, and remember) impairment. The MDS indicated, Resident 14 required maximal assistance (helper does more than half the effort) from staff with eating, oral hygiene, and upper body dressing.During a concurrent interview and record review on 04/24/2026 at 1:14 p.m. with Minimum Data Set Nurse 1 (MDSN1), the records showed Resident 14 screened positive on the PASRR Level I, indicating the need for a PASRR Level II evaluation due to mental illness. Resident 14's review of electronic health record (EHR)contained no evidence of an individualized, interdisciplinary care plan addressing Resident 14's identified mental health or specialized service needs as required. MDSN 1 stated she believed the care plan had been completed; however, upon reviewing Resident 14's EHR no care plan could be found. MDSN 1 stated the facility had not developed or implemented a comprehensive care plan at this time.During an interview on 4/24/2026 at 2:28 p.m. with the Director of Nursing (DON), the DON stated the care plan was missing because the facility failed to complete the PASRR Level II. The DON stated the process lacked clear staff assignment, which led to the followˆup being missed. The DON stated that moving forward, she will implement a process to assign responsibility and ensure all required care plans are completed in a timely manner.During a review of facility's policy and procedure (P&P) titled Preadmission Screening and Resident Review (PASRR) undated indicated Referral: if the Level II evaluation recommends Specialized Services, these must be integrated into the resident's comprehensive care plan within 14 days of admission.Cross reference F644

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 37) received safe and adequate assistance with activities of daily living by failing to provide the required twoˆperson assistance during incontinent care.This failure had the potential to result in injury, accidents, compromised safety, and inadequate personal care.Findings:During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 37 with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), encephalopathy (any damage or disease that affects the brain), and sepsis (life-threatening blood infection).During a review of Resident 37's History and Physical (H&P), dated 1/3/2026, the H&P indicated, Resident 37 did not have the ability to understand and make decisions. The H&P indicated the resident had a tracheostomy (a tube placed into a surgically created hole through the front of the neck and into the windpipe-trachea), a gastrostomy tube (G-tube, a tube placed directly into the stomach for long-term feeding), and a foley catheter (a flexible, thin tube inserted through the urethra into the bladder to drain urine into a collection bag).During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 37's cognitive (ability to think, understand, learn, and remember) skills for daily decision making were severely impaired. The MDS indicated Resident 37 was dependent (helper does all the effort, or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff with oral hygiene, toileting hygiene, showering, personal hygiene, and rolling left and right.During a review of Resident 37's Task List Report, dated 4/21/2026, the Task List Report indicated Resident 37 required two- to three-person assist as needed during turning to maintain spine alignment.During a concurrent observation and interview on 4/21/2026 at 10:21 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 37's room, CNA 1 was observed providing incontinent care to the resident alone, on the left side of the bed. During the care, CNA 1 supported the resident's left side and buttock with one hand while using the other hand to clean him, change the incontinent brief, and replace linens underneath him for approximately 10 minutes. Resident 37 was observed coughing intermittently throughout the resident personal care. CNA 1 stated Resident 37 was typically provided incontinent care by two staff members; however, because the other staff member was busy, she performed the care alone.During a concurrent interview and record review on 4/23/2026 at 10: 15 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 37's Task List Report, dated 4/23/26, was reviewed. RNS 1 stated turning and providing incontinent care to the residents who had tracheostomy, G-tube, and foley catheter were weight bearing tasks. RNS 1 stated Resident 37 was totally dependent and required at least two-person assistance for turning and incontinent care to prevent falls, any accidents or any injury for both the resident and the staff.During an interview on 4/24/2026 at 3: 38 p.m. with the Director of Nursing (DON), the DON stated staff should provide incontinent care with at least two to three staff members for Resident 37, as indicated in the Task List Report, to prevent injury or accident. The DON stated if staff were unsure of the required assistance level, they should ask the resisted nurse for instructions.During a review of the facility's policy and procedure (P&P) titled, Safe Resident Handling, Turning, and Repositioning Residents, dated 2024, the P&P indicated staff shall use sufficient staff assistances as reflected in the president's plan of care.During a review of the facility's P&P titled, Activities of Daily Living (ADL) Performance and Assistance, dated 2024, the P&P indicated staff should assist residents according to their assessed level (independent, supervision, limited assist, expensive assist, total assist) provide care in a safe and timely manner.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 184) received oral hygiene care who was dependent on staff for oral care.This deficient practice had the potential to place Resident 184 at risk for diseases of the mouth, gums, and teeth.Findings:During a review of Resident 184's admission Record, the admission Record indicated Resident 184's was admitted to the facility on [DATE] with diagnoses including, dysphagia (difficulty swallowing) emphysema unspecified (a chronic, progressive lung disease where air sacs (alveoli) are damaged, causing shortness of breath and decreased lung function.), muscle wasting and atrophy (refers to the loss or thinning of muscle tissue). During a review of Resident 184's Minimum Data Set (MDS a resident assessment tool) dated 04/22/2026 indicated Resident 184 with severe cognitive (ability to think, understand, learn, and remember) impairment in decision making. The MDS indicated Resident 184 was dependent (helper does all the effort) in oral hygiene, toileting, shower/bath and substantial /maximal assistance (helper does more than half the effort) for upper/lower body dressing.During a concurrent observation and interview on 04/21/2026 at 10:50 a.m. with Resident 184 and Registered Nurse Supervisor (RNS 3), observed Resident 184 lying in bed with her mouth full of a brown, sticky substance coating the roof of her mouth, tongue, teeth, and lips. Resident 184 stated that her mouth had not been cleaned for a while and she did not know what was inside her mouth. Resident 184 opened her mouth to inspect it more closely. While in the room, RNS 3 came in to assess the substance in the resident's mouth. RNS 3 stated it appeared to be brown crust, not chocolate. RNS 3 gathered supplies and immediately began providing mouth care while waiting for the assigned Certified Nursing Assistance (CNA). RNS 3 used a mouth swab to remove the dry, sticky brown substance and stated she would request the assigned CNA to complete the remaining oral care because it would take additional time and the resident needed to rest, as Resident 184 had requested.During an interview on 04/21/2026 at 11:00 a.m., with CNA 4, CNA 4 stated it was her responsibility to perform mouth care on her residents because it reflects dignity and respect. CNA 4 stated she had Resident 184 on her assignment on 04/20/2026 and again on the day of the observation. CNA 4 stated she did not perform oral care because the resident had a mouth sore, and she was unsure whether the CNA or a licensed nurse should clean the resident's mouth. CNA 4 stated she should have verified with a licensed nurse any concerns instead of ignoring the situation. CNA 4 stated the resident should have still receive oral care and she would provide it immediately.During an interview on 04/23/2026 at 9:51 a.m. with Registered Nurse Supervisor 3 (RNS 3), RNS 3 stated CNAs were required to perform oral care on all residents because providing daily oral hygiene was an essential part of maintaining dignity and respect. RNS 3 stated she immediately assisted in cleaning the resident's mouth to remove the crusted brown substance and improve the resident's comfort. RNS 3 stated staff must ensure residents receive proper care and comfort to prevent further complications.During an interview on 04/24/2026 at 2:27 p.m. with the Director of Nursing (DON), the DON stated CNAs were expected to understand the importance of oral care through constant huddles and in-service training. The DON stated she was surprised oral care had not been completed, as providing oral hygiene reflects dignity and respect. The DON stated CNAs should seek clarification whenever they were unsure whether a resident requires oral care.During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs) Supporting undated, the P&P indicated Residents who are unable to carry out activities of daily living independently will receive the service necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an environment free from accident hazards for two of four sampled residents (Resident 163 and 188).The facility failed to:1.Ensure Certified Nursing Assistant (CNA) 2 was informed of Resident 163's (who was assessed as high risk for fall and had a history of fall) of interventions for fall prevention.2.Ensure Resident 163's bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was functioning and operational when Resident 163 was found on the floor on 4/21/2026.These failures resulted in Resident 163 scooting himself on the floor unnoticed and unassisted by the staff near the doorway of resident's room which can put the resident at risk for serious bodily injury.3. Ensure one of four sampled residents (Resident 188) was repositioned to an upright position prior to meal consumption, as required under standard feeding and aspiration (food or liquid enters the airway/lungs) precaution protocols.These failures resulted in Resident 163 scooting himself on the floor unnoticed and unassisted by the staff near the doorway of resident's room which can put the resident at risk for serious bodily injury.This deficient practice placed Resident 188 at risk for choking and aspiration.Findings: 1.During a review of Resident 163's admission Record, the admission Record indicated Resident 163 was admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 163 with diagnoses including acquired absence of right leg below knee (right lower leg was surgically removed), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), difficulty in walking, metabolic encephalopathy(sudden or gradual decline in brain function), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 163's History and Physical (H&P) dated 11/1/2025, the H&P indicated Resident 163 had fluctuating capacity to understand and make decisions. During a review of Resident 163's Minimum Data Set (MDS- a resident assessment tool) dated 2/6/2026, the MDS indicated Resident 163 had moderately impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 163 required partial/ moderate assistance (helper does less than half the effort to complete an activity) with transferring to and from a bed to a chair or wheelchair, and moving from sitting on the side of the bed to lying flat on the bed. The MDS indicated Resident 163 required substantial/ maximal assistance (helper does more than half the effort) with toileting hygiene, bathing and had a fall since admission in the facility. During a review of Order Summary Report dated 11/3/2025, the Order Summary Report indicated an order to apply bed alarm and to monitor placement and function. During a review of Order Summary Report dated 11/16/2025, the Order Summary Report indicated an order to monitor resident for intentionally getting out of bed unassisted and crawling on the floor. During a review of Resident 163's Care Plan titled, Actual Fall, initiated 11/6/2025, the Care Plan indicated Resident 163 had poor safety awareness (not paying attention to risks or dangers, resulting in a failure to take precautions to prevent accidents), was not compliant with safety precautions and attempted to get out of bed unassisted. The Care Plan indicated interventions included implementing bilateral landing pads, bed alarm, wheelchair alarm (pressure sensitive device designed to alert (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	caregivers immediately when a resident attempts to stand up, helping prevent falls), encouraging patient to use call light and providing assistance as needed. During a review of Resident 163's Fall Risk assessment dated [DATE], the Fall Risk Assessment indicated Resident 63 was a high risk for fall. During a review of Resident 163's Change in Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) dated 4/21/2026 at 10:20 a.m. , the COC indicated Resident 163 was found sitting on the floor in his room and the nature of the incident was unknown. The COC indicated Resident 163 had no signs and symptoms of injury upon assessment, the physician and family were notified. During a review of Resident 163's Care Plan titled, Resident 163 was found sitting on the floor, initiated 4/21/2026, the Care Plan indicated Resident 163 had poor safety awareness, had behavior of attempting to get out of bed unassisted , had episode of crawling out of bed, was a high risk for fall and had a right below knee amputation (BKA- surgical removal of the portion of the leg below the knee). The Care Plan indicated interventions included continuing to implement bilateral landing pads, maintaining a low bed (a specialized, height-adjustable bed that can lower significantly closer to the floor to prevent injuries from falls), encouraging the resident to use the call light, helping the resident as needed, replacing failed sensor alarm, monitoring for any worsening behavior. During an observation on 4/21/2026 at 10:19 a.m. in Resident 163's room, room was dim and Resident 163 was not on the bed but sitting on the right side of the bed. During a subsequent observation on 4/21/2026 at 10:21 a.m. in Resident 163's room, Resident 163 was wearing a shirt and an adult brief (highly absorbent disposable undergarment designed for people with bladder or bowel control issues) and was scooting himself toward the doorway. No audible sound was heard coming from the room. Two unknown staff members walked past the room and did not notice Resident 163 on the floor. Certified Nursing Assistant (CNA) 3 was walking in the hallway, wheeling another resident, when she pointed out Resident 163 on the floor to an unknown staff member. This prompted several staff to enter Resident 163's room. 2.During a concurrent observation and interview on 4/21/2026 at 10:30 a.m. with the Quality Assurance Nurse (QAN) in Resident 163's room, a landing pad (a floor pad designed to help prevent injury should a person fall) was observed on the right side of the bed, a bed pad alarm was present on the bed, and no chair was located on either side of the bed. The QAN stated the bed alarm pad was not functioning and explained that the bed pad alarm activates through pressure. The QAN further stated Resident 163 had a bed pad alarm in place because the resident attempts to get out of bed unassisted. During an interview on 4/21/2026 at 10:37 a.m. with the Central Supply Manager (CSM), the CSM stated the bed pad alarm was not working and would be replaced with a new one. The CSM stated CNAs and licensed nurses notify him when a bed pad alarm is not functioning and needs replacement. The CSM further stated that he does not perform routine checks to ensure bed pad alarm devices are functioning properly During an interview on 4/23/2026 at 10:52 a.m. with CNA 2, CNA 2 stated she did not know that Resident 163 was at high risk for falls and was not familiar with the resident. CNA 2 stated residents (continued on next page)

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Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified as high fall risk wear a yellow wristband, and she did not see a yellow wristband on Resident 163. She stated she saw Resident 163 on 4/21/2026 at approximately 8:40 a.m. while she was picking up breakfast trays, before the resident was later observed on the floor at 10:21 a.m. CNA 2 stated staff are informed during morning huddle if a resident is identified as a high fall risk. She stated that at the time Resident 163 was found on the floor, she was busy assisting other residents. CNA 2 stated she would have checked on the resident hourly and ensured the bed pad alarm was functioning if she had known the resident was at risk for falls. She stated that charge nurses, CNAs, and the maintenance department share responsibility for ensuring bed pad alarms are working. CNA 2 stated she did not check Resident 163's bed pad alarm because the resident was asleep. She stated Resident 163 could be at risk for falls, which could lead to injury if the bed pad alarm was not working, and the alarm is intended to alert staff if the resident moves or falls from the bed. During an interview on 4/23/2026 at 12:13 p.m. with RN Supervisor (RNS) 3, RNS 3 stated Resident 163 could not walk independently and was at high risk for falls due to having an amputated leg and behavioral issues. RNS 3 stated CNAs and licensed nurses are responsible for ensuring bed pad alarm are functioning properly. RNS 3 stated the facility did not hold a morning huddle (a brief daily stand-up meeting of the staff to improve communication, enhance safety and foster teamwork) on 4/21/2026 because of the recertification survey (an unannounced, mandatory, annual inspection conducted by state health department to ensure facilities are following federal safety and quality standards). RNS 3 stated Resident 163 could sustain a fall or injury if staff failed to recognize him as a high fall risk. RNS 3 further stated nonˆworking bed pad alarms can contribute to a resident falling. During an interview on 4/23/2026 at 2:11 p.m. with the Quality Assurance Nurse (QAN), the QAN stated residents identified as high risk for falls can be recognized by a green wristband, a star placed next to the resident's name at the entrance of the room, and a pink slip located at the end of the bed. The QAN stated when staff are unable to identify a resident as a high fall risk, it can lead to residents sustaining injuries or accidents During an interview on 4/24/2026 at 10:40 a.m. with CNA 3, CNA 3 stated she saw Resident 163 on the floor while she was wheeling another resident down the hallway. CNA 3 stated residents at high risk for falls are identified by a green wristband, landing pads, bed and wheelchair pad alarms, and a green star placed by the resident's name at the door. CNA 3 stated she checks residents frequently while they are in bed and responds immediately when a bed pad alarm activates. During an interview on 4/24/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated fallˆprevention measures cannot be implemented effectively if staff are unable to identify residents who are at high risk for falls. The DON stated residents at high risk for falls may sustain a fall when appropriate fallˆprevention interventions are not provided. During a review of facility's policy and procedure (P&P) titled, Fall Prevention Program, dated 2/2025, the P&P indicated the facility will identify interventions and resident specific risks and causes to prevent the resident from falling and minimize complications. The P&P indicated a fall is considered to have occurred when a resident is found on the floor and a fall without an injury is still a fall. 3.During a review of Resident 188's admission Record, the admission Record indicated Resident 188's was admitted to the facility on [DATE] with diagnoses of generalized muscle weakness (a loss of strength across multiple muscle groups), gout unspecified, (form of inflammatory arthritis[inflammation of one or more joints], type 2 diabetes mellitus (DM-disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia (high blood sugar)). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 188's Minimum Data Set ([MDS] – a resident assessment tool), dated 02/23/2026, the MDS indicated, Resident 188's cognitive (ability to think, understand, learn, and remember) skills for daily decision making was intact. The MDS indicated Resident 188 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds truck or limbs and provides more than half the effort) from staff with sit to lying, lying to sitting on the side of bed. Resident 188 needs supervision or touching assistance with eating and oral hygiene. During a concurrent observation and interview on 04/21/2026 at 12:27 p.m. with Resident 188, Resident 188 was observed in bed during lunchtime in a slouched position, sliding downward and unable to safely access her meal tray. Resident 188 stated Certified Nursing Assistant (CNA) 6 delivered her meal tray without repositioning her into an upright position. Resident 188 stated I don't want to report this, but I need to be repositioned. During an interview on 04/21/2026 at 3:19 p.m. with CNA 6, CNA 6 stated she did not intentionally fail to reposition Resident 188. CNA 6 stated Resident 188 requires a twoˆperson assist to be repositioned and pulled up in bed because of the resident's size. CNA 6 stated she had stepped out to find help to reposition Resident 188 for her meal but became busy passing meal trays and forgot to return. CNA 6 stated failing to reposition the resident could cause choking and aspiration. She stated that in the future she will obtain assistance before moving on to the next resident, so she does not forget or become distracted again. During an interview on 04/23/2026 at 10:27 a.m. with Registered Nurse Supervisor 3 (RNS 3), RNS3 stated residents were required to be properly positioned upright at approximately 35 to 45 degrees during mealtimes to prevent choking and aspiration. RNS 3 stated CNAs must ensure residents were comfortable and correctly positioned when delivering meal trays and must reposition residents before leaving the room. During an interview on 04/24/2026 at 2:28 p.m., with the Director of Nursing (DON), the DON stated staff must properly position all residents during mealtimes to reduce the risk of aspiration and choking. During a review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs) Supporting undated, the P&P indicated Appropriate care and service will be provided for residents who are unable to carry out activities of daily living independently, will receive the service necessary to maintain good nutrition, grooming and personal and oral hygiene. Including dining (meals and snacks).

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper urinary catheter care by maintaining the Foley catheter drainage bag below the bladder level during care for one of two sampled residents (Resident 37).This failure had the potential to cause urine backflow into the resident's bladder, increasing the risk for urinary tract infection (UTI- an infection in the bladder/urinary tract) and indwelling catheter-related complications.Findings:During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 37 with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), benign prostatic hyperplasia (BPH, age-associated prostate gland enlargement that can cause urination difficulty) and retention of urine (difficulty emptying the bladder).During a review of Resident 37's History and Physical (H&P), dated 1/3/2026, the H&P indicated, the resident did not have the ability to understand and make decisions. The H&P also indicated Resident 37 had a foley catheter (a flexible, thin tube inserted through the urethra into the bladder to drain urine into a collection bag).During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 1/26/2026, the MDS indicated Resident 37's cognitive (ability to think, understand, learn, and remember) skills for daily decision making were severely impaired. The MDS indicated Resident 37 was dependent (helper does all the effort, or the assistance of 2 or more helpers is required for the resident to complete the activity) on staff with oral hygiene, toileting hygiene, showering, personal hygiene, and rolling left and right.During a review of Resident 37's care plan, titled Indwelling foley catheter with risk of urinary tract infection (UTI- an infection in the bladder/urinary tract), created 1/12/2026, the care plan's interventions included staff should keep drainage bag below bladder level and change bag as needed.During a concurrent observation and interview on 4/21/2026 at 10:21 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 37's room, a foley drainage bag was observed remaining on top of the bed while CNA 1 was providing personal care to the resident approximately for 10 minutes, and the drainage bag was filled with urine. CNA 1 stated she placed the foley drainage bag on top of the bed during personal care to prevent accidental pulling of the catheter/ drainage bag.During an interview on 4/24/2026 at 3:38 p.m. with the Director of Nursing (DON), the DON stated the foley catheter drainage bag should be maintained below the level of the bladder to prevent backflow of urine into the resident's bladder and reduce the risk of urinary tract infection.During a review of the facility's policy and procedure (P&P) titled, Indwelling Urinary Catheter Care, dated 2024, the P&P indicated staff must always keep drainage bag below bladder level.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure adequate hydration for one of three sampled residents (Resident 13), who was visually impaired (unable to see) and required assistance with fluid intake.This deficient practice resulted in Resident 13 becoming dehydrated placing the resident at risk for worsening urinary tract infection (UTI - an infection in the bladder/urinary tract), electrolyte imbalance (when the levels the blood become too high or too low), and potential hospitalization.Findings:During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses including dysphagia (difficulty swallowing), glaucoma (a group of eye conditions that can cause vision loss or blindness), visual loss both eyed, and diabetes mellitus type 2 (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 13's urine culture (a test that checks and identifies germs in a urine sample to check for a urinary tract infection) dated 2/22/2026, the Urine Culture indicated, multi-drug resistant Escherichia coli (E-Coli a type of germ resistant to at least one agent in three or more antibiotics) colony count > 100,000 (normal urine culture result is no growth less than 100,000).During a review of Resident 13's Care Plan Report titled Urinary tract infection dated 3/7/2026, the care plan goal and intervention indicated Resident 13 will maintain adequate hydration (getting enough water and fluids to keep the body working properly).During a review of Resident 13's Minimum Data Set (MDS ?a resident assessment tool) dated 3/16/2026, the MDS indicated Resident 13 required substantial/maximal assistance (helper does more than half) for eating, and oral hygiene.During a review of Resident 13's Basic Metabolic Panel (BMP laboratory test measures kidney health and fluid balance) dated 3/16/2026, the Basic Metabolic Panel indicated the following:Blood Urea Nitrogen (BUN a test that measures the amount of nitrogen from waste in your blood) BUN 46 milligram per deciliter (mg/d-unit of measurement) Reference Range 9-23 mg/dLCreatinine (a waste product produced by the body from normal muscle breakdown) Creatinine- 1.64 mg/dL (Reference Range 0.73- 1.30 mg/dL).During an observation on 4/21/ 2026, at 9:02 a.m. in Resident 13's room, Resident 13 was lying in bed with signage posted above the head of the bed stating, I'm blind please give me water. The bedside table was positioned at the foot of the bed, and the resident's water pitcher was empty. No alternate fluids were available, and the resident had no means to independently access fluids.During an interview on 4/22/2026 at 9:54 am with Resident 13's Resident Representative (RR an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making), the RR stated Resident 13 had vision loss due to glaucoma. The RR stated the facility does not provide the Resident 13 with water throughout the day. The RR stated that during her visits, the Resident 13, bedside table was not within reach, the water pitcher is empty, and no cup available at the bedside. RR stated that she raised these concerns to the staff during the Interdisciplinary Team ([IDT] team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) meetings, but the issue has persisted. RR stated that Resident 13 was treated with intravenous fluid (fluids administered directly into a resident vein) due to dehydration approximately two weeks prior. RR stated that when she came to visit Resident 13 two weeks ago (unknown date) he was sitting in his wheelchair and informed her that he was severely dizzy. RR stated that she informed the staff and instructed them to call the physician. RR stated that the staff obtained Resident 13's vital signs but does not know what they were. RR stated that the next day the facility called her to inform her that Resident 13 would be started on intravenous fluid for hydration.During an observation on 4/22/2026 at 2:47 p.m. Resident 13 was lying in bed, Resident 13's bedside table was not within reach and the water pitcher was empty. During an observation on 4/22/2026 at 4:24 p.m. Resident 13's bedside table was not within reach and the water pitcher was empty. During an interview on 4/23/2026 at 11:46 am with Certified Nurse (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assistant (CNA) 9, CNA 9 stated Resident 13's bedside table should be within his reach at all times and should instruct Resident 13 where the items were placed due to his visual impairment. CNA 9 stated if a resident is not drinking adequate fluids, it should be reported to the charge nurse immediately. CNA 9 stated Resident 13 requires additional assistance compared to other residents due to his visual loss. CNA 9 stated if a resident has no fluids within reach, this indicates the resident was not receiving adequate hydration and could become dehydrated or pass out. CNA 9 stated that it was the staff responsibility to ensure Resident 13 receive adequate fluids in order to maintain their hydrational status.During a concurrent interview and record review on 4/23/2026 at 11:57 a.m. with License Vocational Nurse (LVN) 2, Resident 13's Physician Orders, Summary dated 3/17/2026 and 4/8/2026 was reviewed. The Physician Orders indicated on 3/17/2026 NS to administer Normal Saline (NS intravenous fluid) IV at 60 cubic centimeter (cc-unit of measurement) per hour for three days. Resident 13's Physician Orders, dated 4/8/2026 was reviewed. The Orders indicated, NS at 60 cc per hour for 2 liters, diagnosis of chronic kidney disease (CKD-a long-term condition where the kidneys are damaged) , and dehydration. LVN 2 acknowledged that Resident 13 had received the NS IV due to dehydration. LVN 2 stated the potential complications of inadequate hydration include dehydration, abnormal laboratory values, abnormal vital signs, and possible hospitalization if adequate hydration was not maintained. LVN 2 stated Resident 13's fluids and bedside table should be kept within reach and that staff should ensure that the resident was made aware of the location water pitcher due to his visual impairment.During an interview on 4/24/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated residents identified at risk for dehydration should have fluids offered routinely throughout the day, with intake monitored and documented, and staff should intervene when intake was low. The DON stated residents' who are dependent on staff, including those with visual impairments, require active assistance and prompting to ensure adequate hydration. The DON stated residents who do not receive adequate hydration were at risk for dehydration, urinary tract infection, electrolyte imbalances, and increased confusion. The DON stated that inadequate hydration could lead to more serious complications, including acute kidney injury, worsening infection and potential hospitalization. During a review of the facility's policy and procedure (P&P) titled, Hydration and Nutrition Policy, dated 2024, the P&P indicated, To ensure that all residents receive adequate nutrition and hydration to maintain the highest practicable level of health, prevent malnutrition and dehydration, and support overall will-being.During a review of the facility's P&P titled, Hydration Management Policy, dated 2024, the P&P indicated, The facility shall assess, monitor, and manage each resident's fluid needs to maintain adequate hydration, while accommodating medical conditions, physician orders, and individual preferences.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services for one of two sampled residents (Resident 3) who are receiving enteral feeding (delivers liquid nutrition through a flexible tube that goes directly into the stomach or small intestine). The facility failed to:1.Ensure the tube feeding formula (liquid, specialized nutrition delivered directly to the stomach or small intestine to support health when eating by mouth is not possible or sufficient) was not administered more than 24 hours to Resident 3.This failure had the potential to cause Resident 3 to have intolerance to the tube feeding formula leading to diarrhea (loose stool), nausea, vomiting and inadequate nutrition. Findings:During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was originally admitted to the facility on [DATE] and was readmitted on [DATE]. The admission Record indicated Resident 3 with diagnoses including anoxic brain damage(brain oxygen supply is cut off which can cause long-lasting issues with memory, movement, thinking and personality), dysphagia(difficulty in swallowing), gastrostomy(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem),and cerebral aneurysm(a bulge in a blood vessel in the brain).During a review of Resident 3's History and Physical (H&P) dated [DATE], the H&P indicated Resident 3 did not have the capacity to understand and make decisions.During a review of Resident 3's Order Summary Report dated [DATE], the Order Summary Report indicated an order for Isosource 1.5 (liquid nutrition) at 75 milliliter (ml- unit of measurement) per hour for 10 hours to provide 750 ml via gastrostomy tube (GT- a soft tube surgically inserted directly into the stomach to administer medication, fluids and nutrition) enteral pump and to be turned on at 8:00 p.m. and be turned off at 6:00 a.m.During a review of Resident 3's Minimum Data Set (MDS- a resident assessment tool) dated [DATE], the MDS indicated the resident had moderately impaired cognitive (ability to think, understand, learn, and remember) skills. The MDS indicated Resident 3 was dependent(helper does all the effort) on staff with bathing, toileting hygiene, dressing and transferring to and from a bed to chair.During an observation on [DATE] at 10:44 a.m. in Resident 3's room, Resident 3 was lying in bed and an enteral feeding pump (medical device designed to deliver liquid nutrition through a tube directly into a person's stomach or small intestine) was next to the resident's bed with a tube feeding bag labeled and dated [DATE] at 9:00 p.m. Observed the tube feeding pump was off but still connected to the resident.During a concurrent interview and record review on [DATE] at 9:59 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 3's Order Summary Report and a picture of the tube feeding bag taken on [DATE] were reviewed. LVN 1 stated Resident 3 was receiving Isosource tube feeding at 75 ml per hour for 10 hours. LVN 1 stated Resident 3's tube feeding administration starts at 8:00 p.m. and turns off at 6:00 a.m. LVN1 stated the tube feeding bag was already expired because it was hung on [DATE] at 9:00 p.m. LVN 1 stated tube feeding formula is only good for 24 hours once the tube feeding bag is open and spiked to ensure the integrity of contents are not spoiled or expired. LVN 1 stated she should have discarded the tube feeding bag and the next bag will be hung at 8:00 p.m. LVN 1 stated the charge nurses each shift should check the tube feeding bag for expiration and ensure that it is still good to be administered to the resident. LVN 1 stated Resident 3 can have stomach problems due to the expired tube feeding formula.During an interview on [DATE] at 1:21 p.m. with Registered Nurse Supervisor (RNS) 3, RNS 3 stated tubeˆfeeding formula is usable for only 24 hours after opening, and after 24 hours it is no longer safe for the resident to consume. RNS 3 stated that if expired formula is given, Resident 3 could develop nausea, vomiting, and diarrhea.During an interview on [DATE] at 10:40 a.m. with the Director of Nursing (DON), the DON stated Resident 3 would be at risk for developing nausea, vomiting, stomach upset, and inadequate nutrition if expired tubeˆfeeding formula were administered.During a review of facility's policy and procedure (P&P) titled, Enteral (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nutrition, dated 2024, the P&P indicated staff caring for residents with enteral feedings must ensure accuracy of labeling and dating of each feeding bag or formula container. The P&P indicated label should contain expiration date/ time per manufacturer or facility protocol.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record, review, the facility failed to ensure one of one sampled residents (Resident 8) received appropriate monitoring and labeling of an intravenous (IV- giving medicine, fluids, or nutrition directly into a person's vein using a small tube, allowing it to enter the bloodstream instantly) site who was on IV antibiotic (a medicine that fights infections caused by harmful bacteria) therapy.This failure had the potential to result in IV infiltration(when the IV catheter slips out of the vein, causing fluids or medication to leak into surrounding tissue), leading to pain, tissue injury, and increased risk of infection.Findings:During a review of Resident 8's admission Record, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 8 with diagnoses including multiple sclerosis (a disease in which the immune system attacks the protective covering of the nerves causing nerve damage), respiratory failure (any condition that affects breathing function and results in lungs not functioning properly) and sepsis (a life threatening blood infection).During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 1/4/6/2026, the MDS indicated Resident 8's cognitive (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 8 was dependent (helper does all the effort) on staff with oral hygiene, toileting hygiene, showering, and personal hygiene.During a review of Resident 8's Order Summary Report, dated 4/21/2006, the Order Summary Report indicateda. Starting 4/18/2026, administer Vancomycin HCl Solution (antibiotic medication used to treat sever bacterial infections) one gram intravenously every 12 hours for ventilator-associated pneumonia (a lung infection that develops in a person who is on a ventilator) until 4/24/2026.b. Starting 4/18/2026, monitor peripheral IV site for any signs and symptoms of infection and infiltration: None; Redness; Swelling; Pain; Warm to touch; Infiltration every day and night.During a review of Resident 8's Medication Administration Record (MAR), dated 4/21/2026, the MAR indicated Registered Nurse Supervisor (RNS) 2 started Vancomycin one gram via back of right hand IV access on 4/21/2026 at 8:51 a.m.During an observation on 4/21/2026 at 9:25 a.m. in Resident 8's room, observed Vancomycin 1 gram in a 250ˆmilliliter IV antibiotic infusion through Resident 8's leftˆhand IV access at 125 milliliters per hour (ml/hr-how much liquid flows in one hour). The IV site dressing does not have label for insertion date, time, and staff initialsDuring an interview on 4/21/2026 at 9:45 a.m. with Registered Nurse Supervisor (RNS) 2 in Resident 8's room, RNS 2 stated the resident's IV site dressing lacked the required labeling. RNS 2 stated she had initiated the IV antibiotic infusion at 125 ml/hr approximately one hour before the observation and, upon reassessment, noted that the IV site had infiltrated, with redness and swelling present. RNS 2 acknowledged responsibility for managing the IV.During an interview on 4/24/2026 at 3:38 p.m. with the Director of Nursing (DON), the DON stated staff must label the IV site dressing with the insertion date, time, and their initials to ensure proper rotation. The DON stated staff should monitor the IV site after initiating IV medication, including reassessment approximately 15 minutes after starting the infusion, as part of standard practice. The DON stated Vancomycin may cause phlebitis (inflamed, swollen, and painful vein) as well as discomfort, infiltration, and vein damage, and therefore requires close monitoringDuring a review of the facility's policy and procedure (P&P) titled, Peripheral IV Catheter Insertion, dated 2001, the P&P indicated Staff should label on dressing of the IV insertion site including date and time of dressing placement, initials, gauge size, and length of catheter.During a review of the facility's P&P titled, Intravenous (IV) Medication Administration Policy, dated 2024, the P&P indicated Staff must assess IV site for signs of infiltration, phlebitis, or infection and monitor IV site throughout administration.During a review of the facility's P&P titled, Peripheral IV-line care and Removal, dated 2024, the P&P indicated Staff should assess IV site after medication administration to evaluate for redness, swelling, pain or tenderness, warmth or coolness, leakage, and signs of infiltration or phlebitis.

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Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided according to physician's order and nasal cannula (NC-plastic tube to deliver supplemental oxygen) was dated according to the facility policy and procedure (P&P) for one of one sampled resident (Resident 150).This failure had the potential to result in residents receiving too much oxygen, delayed identification of tubing replacement, and increased the risk of infection. Findings:During a review of Resident 150's admission Record, the admission Record indicated Resident 150 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 150 with diagnoses including hydrocephalus (a condition where too much fluid builds up in the brain's fluid spaces), chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly) and intracranial hemorrhage (a serious medical emergency where a blood vessel brakes and causes bleeding inside the skull or brain).During a review of Resident 150's History and Physical (H&P), dated 5/28/25, the H&P indicated, Resident 150 did not have the ability to understand and make decisions.During a review of Resident 150's Minimum Data Set (MDS- a resident assessment tool), dated 4/14/2026, the MDS indicated Resident 150's cognitive (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 150 was dependent (helper does all the effort) for oral hygiene, toileting hygiene, showering and personal hygiene.During a review of Resident 150's Order Summary Report, physician orders as of 4/21/2026, the Order Summary Report indicateda. Starting 11/2/2024, administer oxygen at 2 liters per minute (L/min-a measurement used to define the flow rate of a gas) via NC to keep oxygen saturation (the percentage of hemoglobin in your red cells carrying oxygen compared to the total amount of hemoglobin available) above 92% (normal range 95%-100%) as needed.b. Starting 11/2/2024, change NC every Saturday night shift. During a concurrent observation and interview on 4/21/2026 at 11:05 a.m. with Resisted Nurse Supervisor (RNS) 3, in Resident 150's room, Resident 150 was observed receiving oxygen through a NC. The NC tubing was observed without a date label indicating when the tubing was last changed. RNS 3 confirmed the oxygen flow rate was set at 3 L/min and the NC tubing lacked the required date label. RNS 3 stated staff are responsible for dating NC tubing upon replacement and changing tubing per facility protocol to promote infection control and ensure timely replacement.During an interview on 4/24/2026 at 3:38 p.m. with the Director of Nursing (DON), the DON stated staff were expected to date NC tubing to promote infection prevention and ensure oxygen was administered in accordance with the physician's order for accurate oxygen delivery.During a review of the facility's policy and procedure (P&P), titled Oxygen Equipment and Tubing Change Policy, dated 2024, the P&P indicated staff should ensure oxygen flow rate matches physician order.During a review of the facility's P&P titled Oxygen Set-Up, dated 2024, the P&P indicated all oxygen tubing must be dated when initiated and when replaced to ensure timely changes and infection prevention compliance. The P&P indicated oxygen tubing shall be dated when initiated or changed near oxygen source end of tubing or another visible location that does not obstruct function.

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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 that one of three sampled residents (Resident 44) with a physician order for fluid restriction (a physician ordered limit on the total amount of liquids resident can consume in 24 hours to prevent fluid buildup in the body) received care and services consistent with the physician order and consistently monitor, implement, or enforce the prescribed fluid restriction. resulting in the resident receiving fluid amounts that exceeded the ordered limit.These failures resulted in Resident 44 receiving fluid amounts that exceeded the physician ordered limit, and placed Resident 44 at risk for adverse health outcomes and demonstrated a lack of adherence to Resident 44's individualized plan of care and physician orders.Findings:During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 44 with diagnoses including end stage renal disease (ESRD - permanent kidney function loss)congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), dependence on renal dialysis (a treatment to cleanse the blood of waste and extra fluids artificially through a machine when the kidneys have failed) and diabetes mellitus type 2 (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 44's Care Plan titled End Stage Renal Disease (ESRD) at risk for fluid volume excess dated 5/21/2025, the Care Plan interventions indicated fluid restriction as ordered.During a review of Resident 44's Order Summary Report dated 2/24/2026, the Order Summary Report indicated, fluid restriction due to: CHF 1000 millimeters (ml a unit of measurement) /24 hours. Total Nursing: 340 ml total;7 a.m. to 3 p.m. shift equals 120 ml, 3 p.m. to 11 p.m. shift equals 120 ml, 11p.m. to 7 a.m. shift = 100 ml. Total Dietary: 660 ml for Breakfast= 360 ml; Lunch= 180 ml; Dinner= 120 ml. every shift record total volume consumed.During a review of Resident 44's Care Plan title : On fluid restriction of 1000 cubic centimeter (cc-unit of measurement) for 24 hours dated 2/24/2026, the care plan goal indicated will observe fluid restriction as ordered daily and be free from signs and symptoms of dehydration and decline in condition will be noted daily for 3 months.During a review of Resident 44's Skin Observation Tool dated 2/25/2026, the Skin Observation Tool indicated, positive (+) edema (swelling caused by excess fluid trapped in the body's tissues) of left foot and 1+ edema of the right foot.During a review of Resident 44's History and Physical (H&P) dated 3/1/2026, the H&P indicated, Resident 44 had the capacity to consent, however with mild cognitive(ability to think, understand, learn, and remember) impairment.A review of Resident 44's Weights and Vitals Summary indicated the following:12/21/2025 155 (Lbs-unit of measurement)01/04/2026 161 Lbs02/03/2026 160 Lbs02/26/2026 156 Lbs03/01/2026 157 Lbs03/06/2026 156 Lbs03/15/2026 154 Lbs03/22/2026 155 Lbs04/07/2026 163 Lbs.During an observation on 4/22/2026 at 7:49 a.m. Resident 44 was observed lying in bed with oxygen in use at two liters via nasal cannula (device used to deliver oxygen). Resident 44 had bilateral lower extremity ([BLE] both feet right and left) and bilateral upper extremity ([BUE] both arms right and left) edema (swelling) noted. Resident 44 had multiple food and beverage items located on bedside table including one can of soda, chips, pastries, and three Gatorade. During an interview on 4/23/2026 at 8:58 a.m. with Certified Nurse Assistant (CNA) 8, CNA 8 stated Resident 44 was on fluid restriction; however, CNA 8 was unable to state the resident's current fluid allowance. CNA 8 stated that she identifies fluid-related information from the resident's meal ticket (is a personalized card or electronic record that ensures a resident receives the correct food based on their specific dietary needs, allergies, and preferences). CNA 8 stated water, juice, and milk were considered fluids. CNA 8 stated t during her shift she provides fluids to Resident 44 based on his preferences, including offering alternative beverages if the resident does not like the initially provided option. CNA 8 stated fluids were left at Resident 44's bedside and were not controlled or restricted. CNA 8 stated that she does not understand the purpose of a fluid restriction (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or the potential consequences of exceeding the ordered limit. CNA 8 stated she does not monitor or track the resident's fluid intake, does not total intake during or after her shift, and does not document fluid intake. CNA 8 stated she had not received training on monitoring or documenting fluid intake. CNA 8 stated she was not informed of the resident's fluid restriction through shift report or the resident's care plan. CNA 8 stated that she had not communicated any concerns regarding the Resident 44's fluid intake because the other nursing staff allows the resident to have fluids as desired. During a concurrent interview and record review on 4/23/2026 at 9:31 a.m. with License Vocational Nurse (LVN) 4, Resident 44's Medication Administration Record (MAR) dated April 2026 was reviewed. The MAR indicated, fluid restriction due to CHF 1000 ml/24 hours. LVN 4 stated that a resident's fluid restriction status was communicated to staff through the MAR. LVN 4 stated the CNAs were responsible for reporting to the license staff the resident's fluid intake during their shifts, but they are not responsible for documenting the resident's fluid intake during their shifts. LVN 4 stated that the total daily fluid intake is calculated and documented by the license nurses. LVN 4 stated that signs and symptoms of fluid overload include edema, crackles 9abnormal breath sounds) , shortness of breath, and weight gain. LVN 4 stated that Resident 44 had exhibited bilateral upper and lower extremity edema, and crackles while breathing and has experienced weight gain. LVN 4 confirmed that she had not reported those signs and symptoms to the physician. LVN 4 stated she does not know why she did not report the signs and symptoms to the physician, and acknowledged that the signs and symptoms should be reported to the physician immediately to avoid further complications such as hospitalization. During a concurrent interview and record review on 4/23/2026 at 10:20 a.m. with LVN 4, Resident 44's Medication Administration Record (MAR) dated April 2026 was reviewed, the MAR indicated the following:4/1/2026 Day shift 700 ml, Evening shift 700 ml, Night shift 100 ml= 1500 ml4/2/2026 Day 540 ml, Evening 400 ml, Night 100 ml= 1040 ml4/3/2026 Day 540 ml, Evening 540 ml, Night 100 ml= 1140 ml4/4/2026 Day 540 ml, Evening 540 ml, Night 540 ml= 1620 ml4/7/2026 Day 700 ml, Evening 700 ml, Night 100 ml= 1500 ml4/8/2026 Day 800 ml, Evening 600 ml, Night 100 ml= 1500 ml4/10/2026 Day 360 ml, Evening 900 ml, Night 100 ml= 1330 ml4/11/2026 Day 800 ml, Evening 240 ml, Night 240 ml= 1280 ml4/22/2026 Day 800 ml, Evening 800 ml, Night 800 ml= 2400 mlLVN 4 acknowledged Resident 44 had exceeded the prescribed fluid restriction and potential adverse outcomes of fluid overload include edema, shortness of breath, crackles, weight gain and hospitalization.During an interview with the Director of Nursing (DON), the DON stated residents receiving dialysis were assessed upon admission and routinely thereafter for fluid balance, weight trends, and risk for fluid overload or dehydration. The DON stated physician-ordered fluid restrictions are implemented into the care plan, dietary plan, nursing documentation, and includes tracking intake and output. The DON stated nursing staff were responsible for monitoring daily weights, intake, and observing for signs of fluid imbalance. The DON stated if noncompliance or failure to follow fluid restrictions was identified, staff should immediately notify the physician, reassess the resident, and update the care plan. The DON stated interventions may include increased monitoring, staff education, resident/family education, and possibly adjusting the fluid restriction order. The DON stated that failure to follow fluid restrictions can lead to serious complications including fluid overload, respiratory distress, congestive heart failure exacerbation, elevated blood pressure, hospitalization risk, and in severe cases death.During a review of the facility's policy and procedures (P&P) titled Fluid Restriction Management, dated 2024, the P&P indicated The facility will implement fluid restrictions only with a valid physician order or licensed provider order. All staff will adhere to prescribed limits, monitor intake accurately, and educated residents and families regarding compliance.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act on recommendations from the consultant pharmacist (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) from 1/29/2026, 2/27/2026 and 3/29/2026 regarding clarifying Resident 10's diagnosis to support the use of Seroquel (generic name - quetiapine, a medication used to treat schizophrenia (a mental illness that is characterized by disturbances in thought), affecting one of five residents sampled for review of unnecessary medications (Resident 10). This deficient practice of failing to respond to recommendations from the consultant pharmacist resulted in Resident 10 receiving quetiapine for an unclear diagnosis and/or indication possibly resulting in medication side effects (a secondary, typically undesirable effect of a drug or medical treatment) leading to a decrease in physical, mental, or psychosocial well-being.Findings:During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 10 with diagnoses including but not limited to unspecified dementia (a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, generalized anxiety disorder (a condition where someone worries constantly about everyday issues and situations), recurrent major depressive disorder (sadness, low mood).During a review of Resident 10's Psychiatry (branch of medicine focused on diagnosis, treatment and prevention of mental disorders) note, dated 7/1/2025, the Note indicated, Psych consult requested for med/behavior review.On trazodone (a medication used to treat depression) 50 mg.every hour of sleep (hs-daily at bedtime) for insomnia (difficulty falling and staying asleep). No other psych meds. Following admission.patient was agitated and restless.No other major behavioral issues reported. Sleep good. Dx (diagnoses): Alcohol (ETOH) use disorder, ETOH induced sleep disorder, unspecified insomnia disorder.During a review of Resident 10's Medication Regiment Review (MRR - a monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) dated 1/29/2026, the review indicated the following note from the consultant pharmacist, Resident 10: MRR date 1/22/2026: Clarify for diagnosis and appropriate behavior. Seroquel oral tablet 25 mg (Quetiapine fumarate), give 25 mg by mouth two times a day for agitation. There were no follow-through notes documented.During a review of Resident 10's MRR dated 2/27/2026, the review indicated the following note from the consultant pharmacist, Resident 10: Seroquel oral tablet 50 mg (Quetiapine fumarate) give one tablet by mouth two times a day for agitation manifested by (m/b) tries to jump out of the bed, *Note to follow up (f/u) with doctor to clarify underlying diagnosis. Please f/u to evaluate monitoring of all indicated behavior(s) and potential side-effect(s) for Quetiapine on the Medication Administration Record. The follow-through indicated, Dementia with behavioral disturbances.During a review of Resident 10's Physician's Note titled, Nursing Home Visit dated 3/23/2026, electronically signed by physician at 4/23/2026 at 10:08 p.m., the document indicated, Subjective: follow up visit in person. Meds reviewed. Staff consulted. Since last visit, Seroquel and prn Ativan ([generic name: lorazepam] a medication used to treat anxiety) added. Patient is still restless manifested by wheeling around facility but less agitated since Seroquel added. Verbalizations are repetitive. No current difficulty with sleep. No side effects reported. Assessment: Improved from last visit. Diagnosis: ETOH (alcohol) use disorder, Unspecified sleep disorder, Unspecified mood disorder. Plan: Change indication for Seroquel to Mood Instability m/b agitated outbursts.During a review of Resident 10's Minimum Data Set (MDS resident assessment tool), dated 3/24/2026, the MDS did not indicate a cognition (ability to think, understand, learn, and remember) score. The MDS indicated Resident 10 needed maximal assistance from facility for Activities of Daily Living (ADLs) such as eating, oral hygiene, upper body dressing (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and personal hygiene, and was dependent on facility staff for toileting hygiene, showering, lower body dressing and putting on/taking off footwear. The MDS indicated diagnoses for Resident 10 were not-Alzheimer's, dementia, anxiety disorder and depression.During a review of Resident 10's MRR dated 3/29/2026, the review indicated the following note from the consultant pharmacist: Resident 10: Seroquel oral tablet 50 mg (Quetiapine fumarate) give one tablet by mouth two times a day for mood instability m/b agitated outburst, Note to follow up (f/u) with doctor to clarify underlying diagnosis. There were no follow-through notes documented.During a review of Resident 10's Order Summary Report , dated 4/5/2026, the Order Summary Report indicated but not limited to the following physician orders: Seroquel oral tablet 50 milligram ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for mood instability manifested by (m/b) agitated outburst, non-pharmacological intervention (NPI): 1 = Re-assurance, 2 = Redirection, 3 = Relaxation technique, 4 = calming environment, 5 = gentle massage, 6 = Meaningful activities, 7 = Other, order date 3/23/2026, start date 3/24/2026.The facility did not provide Resident 10's active orders as of 4/22/2026 and/or 4/23/2026 as per request.During a review of Resident 10's MAR dated 4/1/2026 to 4/22/2026, the MAR indicated Seroquel oral tablet 50 mg was administered 44 times to Resident 10.During a review of Resident 10's MAR dated 3/1/2026 to 3/31/2026, the MAR indicated Seroquel oral tablet 50 mg was administered 48 times to Resident 10.During a review of Resident 10's MAR dated 2/1/2026 to 2/28/2026, the MAR indicated Seroquel oral tablet 25 mg was administered 51 times to Resident 10.During a concurrent interview and record review on 4/23/2026 at 3:29 p.m. with Licensed Vocational Nurse (LVN) 6, Resident 10's electronic medical records and physical chart notes were reviewed. LVN 6 stated Resident 10 was on Seroquel for angry outbursts related to agitation and episodes of wandering (walk around without any clear purpose or direction) at times and screaming. LVN 6 stated Resident 10 should have been evaluated by a psychiatrist for his illnesses. LVN 6 stated she could not find any psychiatrist notes.During the interview on 4/23/2026 at 5:19 p.m., with the Director of Nursing (DON), the DON stated after the consultant pharmacist submitted MRR recommendations, the DON reviewed them as soon as the following day and attempted to address them before the next review date. The DON stated difficulty reviewing the volume of material, noting there were 600 pages and not enough time to review them all. The DON stated residents were routinely seen by a psychiatrist at least quarterly. The DON stated the psychiatric consult had not been uploaded into the facility's electronic health record system, but confirmed that a consult existed and would need to be located. When asked about Resident 10, the DON stated they had requested the psychiatrist to see the resident. The DON added that if a resident's medication list did not contain the correct diagnosis, they would ask the physician to reevaluate.During a review of the facility's policy and procedure (P&P) titled, Medication Regimen Review (MRR) Policy, dated 2024, the P&P indicated, A licensed pharmacist shall conduct . (MRR) for each resident at least monthly. Identified irregularities shall be reported to the attending physician and Director of Nursing (DON) with prompt follow-up and resolution. The P&P indicated, Scope of Review: the MRR shall include, but is not limited to: Medication appropriateness (indication, dose, duration). The P&P indicated, Physician Response: The attending physician must: Review and respond to reported irregularities; Indicate agreement, disagreement or alternative action; Responses must be documented in the medical record. The P&P indicated, Timeliness of Action: Identified issues shall be addressed promptly; Urgent concerns.immediately.During a review of the facility's P&P titled, Psychotropic Medication Management Policy, dated 2024, the P&P indicated, Psychotropic medications shall be used only when clinically indicated, prescribed in accordance with accepted standards of practice, and monitored.safety. The P&P indicated, General Requirements: Each psychotropic medication must have: a documented clinical indication/diagnosis.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 40) was free from unnecessary drugs. The facility failed to:1.Monitor Resident 40 for side effects (secondary effects of a medication that may be beneficial or harmful) and adverse reactions (undesirable, harmful effects) associated with opioid (class of drugs used to reduce moderate to severe pain and can affect brain areas controlling emotion and breathing) use. Resident 40 was receiving Oxycodone (strong, addictive opioid medication used to manage severe and ongoing pain) 15 milligrams (mg- unit of measurement) by mouth every six hours and 7.5 mg (half tablet) at bedtime, and Morphine Sulfate (prescription-only potent narcotic pain reliever) 15 mg by mouth every 12 hours, both of which are potent opioid medications used to manage severe and ongoing pain.This failure had the potential to result in Resident 40 experiencing an unrecognized and unidentified adverse side effect (undesirable harmful effect) from the use of opioids. Findings:During a review of Resident 40's admission Record, the admission Record indicated Resident 40 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 40 with diagnoses including chronic pain (pain last or persist for months or even years, continuing beyond the recovery time of an illness), heart failure (heart muscle is unable to pump enough blood to meet the body's needs for blood and oxygen) and difficulty in walking.During a review of Resident 40's Care Plan titled, Resident is at risk for pain and is on pain medication therapy, initiated 10/9/2021 the Care Plan indicated the resident is on Oxycodone and Morphine Sulfate tablets. The Care Plan's goal indicated the resident will be free of any discomfort or adverse side effects from pain medication. The Care Plan interventions included monitoring, documenting, reporting as needed (prn) adverse reactions to analgesic therapy (medications used in the management and treatment of pain).During a review of Resident 40's Minimum Data Set (MDS- a resident assessment tool) dated 2/23/2026, the MDS indicated Resident 40 had an intact cognition (ability to think, understand, learn, and remember) and required supervision or touching assistance (helper provides verbal cues as resident completes the activity) with bed mobility, dressing and personal hygiene. The MDS indicated Resident 40 is on opioid medication.During a review of Resident 40's Order Summary Report dated 4/3/2026, the Order Summary indicated an order of Morphine Sulfate oral tablet 15 mgs. one tablet by mouth every 12 hours for chronic pain (pain that lasts longer than three months).During a review of Resident 40's Order Summary Report dated 4/4/2026, the Order Summary indicated an order of Oxycodone 15 mgs. give 0.5 tablet (7.5 mgs.) by mouth at bedtime for chronic pain syndrome.During a review of Resident 40's Order Summary Report dated 4/4/2026, the Order Summary Report indicated an order of Oxycodone 15 mgs, 1 tablet by mouth every 6 hours for chronic pain syndrome.During a concurrent interview and record review on 4/24/2026 at 11:25 a.m. with Registered Nurse Supervisor (RNS) 4, Resident 40's Medication Administration Record (MAR) and Order Summary Report were reviewed. RNS 4 stated that there was no monitoring documented for side effects related to Oxycodone and Morphine Sulfate. RNS 4 explained that depressed respiratory rate (abnormally slow breathing that can impair breathing effectiveness), low blood pressure, cold and clammy skin, and sedation (a state of sleepiness or decreased awareness) are known side effects of Oxycodone and Morphine Sulfate. RNS 4 stated that licensed nurses should monitor residents for opioidˆrelated side effects to ensure Resident 40's safety. RNS 4 further stated that Resident 40 could go into respiratory arrest (a cessation of breathing which, without immediate intervention, can lead to death or brain injury) if staff fail to monitor for these side effects.During an interview on 4/24/2026 at 3:15 p.m. with the Director of Nursing (DON), the DON stated central nervous system depression (a condition characterized by slowed or abnormal breathing, decreased heart rate, and reduced consciousness) and respiratory depression (slow, shallow breathing that prevents proper gas exchange in the lungs) are known side effects of Morphine and Oxycodone. The DON stated Resident 40 could experience respiratory (continued on next page)

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	056433	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	depression (a lifeˆthreatening, often drugˆinduced condition in which breathing becomes too slow or shallow, leading to low blood oxygen levels and excessive carbon dioxide buildup [body is producing too much waste gas and the lungs are unable to breathe them out effectively]) if staff do not monitor for these side effects. The DON stated this lack of monitoring could place Resident 40 at risk for hospitalizationDuring a review of facility's policy and procedure (P&P) titled, Monitoring Medication Adverse Effects, dated 2024, the P&P indicated identifying, monitoring, documenting and responding to adverse drug effects in patients will ensure safe administration of medications.During a review of facility's P&P titled, Unnecessary Medication. Dated 2024, the P&P indicated all staff and individuals involved in prescribing, administering medications should evaluate the medications for drug interactions, duplications and side effects.

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 maintain a medication error rate of less than 5 percent (%) during medication pass for two of six sampled residents (Residents 128 and 159) by failing to:1. Ensure Resident 128's Keppra ([generic name - levetiracetam] a medication used to treat seizures {a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness}) was administered within one hour before or after its scheduled time of administration, as per facility's policy and procedure (P&P) titled, Medication Timing of Administration Policy, dated 2024.2. Ensure Resident 159's gastrostomy tube ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem) was flushed with water before and after natural psyllium husk (medication to treat constipation) was administered via g-tube, in accordance with physician orders.These deficient practices failed to administer medications in accordance with physician orders and professional standards of practice, which resulted in a medication error rate of 6.67% which exceeded the five (5) percent threshold, and placed Residents 128 and 159 at risk for seizures, g-tube occlusion and/or complication, resident discomfort and hospitalization. Findings:1. During a review of Resident 128's admission Record, the admission Record indicated, Resident 128 was originally admitted to facility on 2/9/2026 and readmitted on [DATE]. The admission Record indicated Resident 128 with diagnoses including but not limited to hemiplegia (total paralysis [loss of muscle function in part of the body] on one side of the body) and hemiparesis (partial muscular weakness on one side of the body) following cerebral infarction (stroke- loss of blood flow to a part of the brain) affecting left dominant side, gastrostomy, seizures and cerebral infarction without residual deficits, long term (current) use of anti-thrombotic (medications that reduces formation of blood clots)/antiplatelets (medications that prevents blood cells from sticking together and forming a blood clot) and essential hypertension (high blood pressure).During a review of Resident 128's Minimum Data Set ([MDS], a resident assessment tool) dated 2/16/2026, the MDS indicated Resident 128 was rarely or never understood so there was no cognition (ability to think, understand, learn, and remember) score. The MDS indicated, Resident 128 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.During a concurrent observation and interview on 4/21/2026 between 9:59 a.m. and 11:22 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared the following 13 medications, and Prostat (a protein supplement), to be administered to Resident 128 via g-tube. LVN 2 stated he did not have calcium carbonate (a medication used to relieve acid-reflux) 600 milligram (mg-used for medication dosage and/or amount)) to administer for Resident 128 during medication pass. LVN 2 checked Resident 128's blood pressure using a manual blood pressure monitor and stated Resident 128's blood pressure was 132/76 millimeters of mercury (mmHg - a measurement of pressure) and heart rate was 84.a. One tablet of amlodipine (a medication used to treat HTN) 10 mg with instructions to hold for systolic blood pressure ([SBP] the pressure caused by heart while contracting) of less than 110 mmHg and pulse rate of less than 60.b. One drop of artificial tears eye drops (temporary relief for dry, irritated, or fatigued eyes) in both eyesc. One tablet of aspirin (a medication used to prevent blood clots) 81 mg chewabled. One tablet of vitamin D (a vitamin used to treat low level of vitamin D and to support immune function and muscle strength) 25 micrograms ([mcg] a unit of measurement for mass)e. 10 milliliters ([mL] a unit of measurement for volume) of docusate sodium (a medication used to treat constipation [problem with passing stool]) 50 mg/5 mLf. One-half (1/2) tablet of ezetimibe (a medication used to treat bad cholesterol) 10 mgg. 7.5 mL of ferrous sulfate (an iron supplement used to treat anemia and low level of iron) 220 mg/5 mLh. 30 mL (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of lactulose (a medication used to treat constipation and brain dysfunction) 10 grams ([gm] a unit of measurement for mass)/15 mLi. Five (5) mL of Keppra ([generic name - levetiracetam] a medication used to treat seizures) 100 mg/mLj. 15 mL of Elder Tonic (a supplement with vitamins B and minerals to support body functions)k. Five (5) mL of vitamin C (a vitamin used to improve immune function and treat low levels of vitamin C) 500 mg/5 mLl. 10 mL of Chlorhexidine (a disinfectant and antiseptic) 0.12% to be administered buccally (in the cheek) for oral carem. One tablet of losartan (a medication used to treat HTN) 50 mg with instructions to hold if SBP of less than 110LVN 2 was not able to swab and cleanse oral cavity with chlorhexidine rinse because Resident 128 did not open her mouth. LVN 2 stated he was supposed to dilute the Prostat with water before administering it via g-tube because the g-tube was clogging during medication administration. LVN 2 stated he needed to change the valve before resuming medication administration. LVN 2 completed administration of 13 medications and Prostat on 4/21/2026 at 11:22 a.m.During an interview on 4/21/2026 at 12:00 p.m. with Registered Nurse Supervisor (RNS) 3, RNS 3 stated LVN 2 should have reached out for help when he (LVN 2) was running late for administering medications at Station A Medication Cart 1. RNS 3 stated the medications should have been administered one hour before or one hour after scheduled administration time.During the interview on 4/21/2026 at 12:42 p.m., with the Director of Nursing (DON), the DON stated the LVN may have been nervous. The DON stated if the surveyor began observing LVN 2 at 9:59 a.m., LVN 2 should have completed the 9 a.m. medication administration by 10 a.m., as nurses are allowed one hour before and one hour after the scheduled administration time.During a review of Resident 128's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated but not limited to the following physician orders: Levetiracetam oral solution 500 mg/5 mL, give 5 mL via g-tube every 12 hours for seizure disorder (5 mL = 500 mg), order date 3/15/2026, start date 3/15/2026. Monitor for seizure activity. Document (Y/Yes) present, (N/No) not present. Call medical doctor (MD) if present every shift, order date 3/15/2026, start date 3/15/2026.During a review of Resident 128's Medication Admin Report (MAR), dated 4/21/2026, the Medication Admin Report indicated, Resident 128's levetiracetam oral solution were administered on 4/21/2026 at 10:14 a.m. However, Resident 128's levetiracetam and other medications were observed being administered via g-tube to Resident 128 on 4/21/2026 at 11:22 a.m. during medication pass. The Medication Admin Report indicated that the documented date and time for Resident 128's levetiracetam oral solution on 4/21/2026 was at 11:27 a.m.During a review of Resident 128's Medication Admin Audit Report, dated 4/22/2026, schedule date 4/1/2026 to 4/22/2026, there were 15 times when scheduled administration for levetiracetam oral solution 500 mg/5 mL via g-tube every 12 hours at 9:00 a.m., was administered late after 10:15 a.m. with instances of it being administered at 1:20 p.m.During an interview on 4/21/2026 at 3:39 p.m. with LVN 2, LVN 2 stated Resident 128's medications including Keppra were administered late on 4/21/2026 by over one hour because according to facility's policy, medications should have been administered as early as one hour before and as late as one hour after scheduled time of medication administration. LVN 2 stated the Keppra might not be effective and Resident 128 was placed at risk for seizures and hospitalization. During the interview on 4/23/2026 at 4:38 p.m., the Director of Nursing (DON). The DON stated she conducted an inˆservice education for the facility nurses regarding late medication administration. The DON stated there was a risk for adverse effects when residents did not receive their medications on time. She further stated that the physician informed her that there would be a risk for seizures if a resident did not receive Keppra or if a dose was omitted, as this could lead to low Keppra levels. 2. During a review of Resident 159's admission Record, the admission Record indicated, Resident 159 was originally admitted to the facility on [DATE] and readmitted on [DATE]. The admission Record indicated Resident 159 with diagnoses that included but not limited to hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left dominant side, dysphagia (difficulty swallowing) following nontraumatic intracerebral hemorrhage (formation of hematoma [clotted blood] with or without blood extension into the ventricles), gastrostomy (g-tube) status and other bacterial (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	infections of unspecified site.During a review of Resident 159's MDS dated [DATE], the MDS indicated Resident 159 was rarely or never understood so there was no cognition score. The MDS indicated the facility did not attempt assessment for eating due to medication condition or safety concerns. The MDS indicated Resident 159 was dependent on the facility staff for performing ADLs such as oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing and putting on or taking off footwear.During a review of Resident 159's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated but not limited to the following physician orders: Enteral Feed Order as needed, may transfer to hospital for g-tube re-insertion if clogged/dislodged/pulled out/leaking, order date 2/24/2026, start date 2/24/2026. Enteral Feed Order every shift flush feeding tube with 30 mL water before and after medication administration, order date 2/24/2026, start date 2/24/2026. Psyllium Husk Powder, give 7 grams ([gm] a unit of measurement for mass) via g-tube every 8 hours for bowel management (1 teaspoon = 7 gm), order date 3/6/2026, start date 3/6/2026. Insulin (medication to lower blood sugar) NPH (Human) (Isophane) subcutaneous (under the skin) suspension pen-injector 100 units/mL, inject 16 units subcutaneously every eight hours for diabetes mellitus, hold if fasting blood sugar <120 mg/deciliter ([dL] a unit of measurement for volume), rotate injection sites, order date 2/26/2026, start date 2/27/2026.During a concurrent observation and interview on 4/21/2026 at 2:47 p.m. with LVN 3, LVN 3 prepared the following two medications for Resident 159.a. 16 units of Novolin N (a type of insulin used to treat high blood sugar) 100 units/mL injected under the skin, with instructions to hold if blood sugar was less than 120.b. One teaspoon (5 mL) of psyllium husk powder dissolved in 240 mL water.During an observation on 4/21/2026 at 2:47 p.m. in Resident 159's room, LVN 3 administered the psyllium husk solution via g-tube to Resident 159. LVN 3 did not flush the g-tube with 30 mL water before and after administering psyllium husk.During the interview on 4/21/2026 at 3:12 p.m., LVN 3 stated making an error. LVN 3 stated it was important to flush the gˆtube with water before and after medication administration to prevent clogging of both the gˆtube and the syringe. During the interview on 4/23/2026 at 4:50 p.m., with the DON, the DON stated the nurse should have flushed the gˆtube with 30 mL of water before and after administering psyllium husk, in accordance with the physician's order, to prevent clogging of the gˆtube. During a review of the facility's P&P titled, Medication Timing of Administration Policy, dated 2024, the P&P indicated, 1. Standard Administration Time Frames. Routine medications shall be administered within a one-hour window before or after the scheduled time (e.g., 8:00 AM dose given between 7:00 AM and 9:00 AM). Critical medications shall be administered at the exact time ordered or within a more restrictive window as defined below. 2. Medications considered time-critical must be . within 60 minutes before or after the scheduled time, unless otherwise specified by the prescriber. Examples include: Insulin (rapid-acting), Anticoagulants (e.g., warfarin, heparin), Antibiotics with specific dosing intervals, Anti-seizure medications, Medications with short half-lives or requiring consistent blood levels. The P&P indicated, 5. Missed or Late Doses. If a medication is not administered within the allowable time frame: The nurse shall assess the situation.if necessary. The dose shall not be automatically .without an order, Documentation must include: Reason for delay or omission.actions taken.notifications made.During a review of the facility's P&P titled, Medication Administration, dated 2024, the P&P indicated, Medications shall be administered safely, accurately, and timely in accordance with physician orders, accepted standards of practice,.outcomes.During a review of the facility's P&P titled, Gastrostomy (g-tube) Medication Administration, dated 2024, the P&P indicated, Medications administered via G-tube shall be given safely and accurately, using proper technique to prevent tube occlusion, medication errors, and infection. The P&P indicated, 3. Administration Procedure- 1. Stop feeding if applicable, 2. Flush tube per protocol, 3. Administer medications one at a time, 4. Flush between medications, 5. Flush after final medication, 6. Resume feeding as ordered.(Cross-referenced with F755)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent a significant medication error for one out of six sampled residents (Resident 128) during medication administration, by failing to administer Resident 128's Keppra ([generic name - levetiracetam] a medication used to treat seizures) within one hour before or after its scheduled time of administration, as per facility's policy and procedure (P&P) titled, Medication Timing of Administration Policy, dated 2024.This deficient practice failed to ensure Resident 128's Keppra was administered in accordance with physician's orders or professional standards of practice and had the potential to result in seizures and hospitalization.Findings:1. During a review of Resident 128's admission Record, the admission Record indicated, Resident 128 was originally admitted to facility on 2/9/2026 and readmitted on [DATE]. The admission Record indicated Resident 128 with diagnoses including but not limited to hemiplegia (total paralysis [loss of muscle function in part of the body] on one side of the body) and hemiparesis (partial muscular weakness on one side of the body) following cerebral infarction (stroke- loss of blood flow to a part of the brain) affecting left dominant side, gastrostomy ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem), seizures and cerebral infarction without residual deficits, long term (current) use of anti-thrombotic (medications that reduces formation of blood clots)/antiplatelets (medications that prevents blood cells from sticking together and forming a blood clot) and essential hypertension (high blood pressure).During a review of Resident 128's Minimum Data Set ([MDS], a resident assessment tool) dated 2/16/2026, the MDS indicated Resident 128 was rarely or never understood so there was no cognition (ability to think, understand, learn, and remember) score. The MDS indicated, Resident 128 was dependent on facility's staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, oral hygiene, toileting hygiene, showering, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene.During the concurrent observation on 4/21/2026 between 9:59 a.m. and 11:22 a.m., with Licensed Vocational Nurse (LVN) 2, prepared and administered 13 medications, including 5 mL of Keppra 100 mg/mL oral solution, to be given to Resident 128 via gastrostomy ([g-tube] a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problem).During an interview on 4/21/2026 at 12:00 p.m., with Registered Nurse Supervisor (RNS) 3, RNS 3 stated LVN 2 should have requested assistance when he was running late with medication administration at Station A Medication Cart 1. RNS 3 stated medications should be administered within one hour before or one hour after the scheduled administration time.During the interview on 4/21/2026 at 12:42 p.m., with the Director of Nursing (DON), the DON stated LVN 2 may have been nervous. The DON stated if the surveyor began observing LVN 2 at 9:59 a.m., LVN 2 should have completed the 9 a.m. medication administration by 10 a.m., as nurses are allowed one hour before and one hour after the scheduled administration time. During a review of Resident 128's Order Summary Report, dated 4/22/2026, the Order Summary Report indicated but not limited to the following physician orders: Levetiracetam oral solution 500 mg/5 mL, give 5 mL via g-tube every 12 hours for seizure disorder (5 mL = 500 mg), order date 3/15/2026, start date 3/15/2026. Monitor for seizure activity. Document (Y/Yes) present, (N/No) not present. Call medical doctor (MD) if present every shift, order date 3/15/2026, start date 3/15/2026.During a review of Resident 128's Medication Admin Report, dated 4/21/2026, the Medication Admin Report indicated, Resident 128's levetiracetam oral solution were administered on 4/21/2026 at 10:14 a.m. However, Resident 128's levetiracetam and other medications were observed being administered via g-tube to Resident 128 on 4/21/2026 at 11:22 a.m. during medication pass. The Medication Admin Report indicated that the documented date and time for Resident 128's levetiracetam oral solution on 4/21/2026 was at 11:27 a.m.During a (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review of Resident 128's Medication Admin Audit Report, dated 4/22/2026, schedule date 4/1/2026 to 4/22/2026, there were 15 times when scheduled administration for levetiracetam oral solution 500 mg/5 mL via g-tube every 12 hours at 9:00 a.m., was administered late after 10:15 a.m. with instances of it being administered at 1:20 p.m.During an interview on 4/21/ 2026, at 3:39 p.m., with LVN 2, LVN 2 stated Resident 128's medications, including Keppra, were administered more than one hour late. LVN 2 stated according to the facility's policy, medications should be given no earlier than one hour before and no later than one hour after the scheduled administration time. LVN 2 stated the delayed administration could reduce the effectiveness of Keppra and place Resident 128 at risk for seizures and possible hospitalization.During an interview on 4/23/2026 at 4:38 p.m. with the DON, the DON stated she conducted an in-service for the facility nurses regarding late administration of medications. The DON stated there was a risk for adverse effects if the facility residents did not receive medications on time. The DON stated the physician informed her (DON) that there would be a risk for seizures if the resident did not receive or if Keppra was omitted because it could cause low levels of Keppra.During a review of the facility's P&P titled, Medication Timing of Administration Policy, dated 2024, the P&P indicated, 1. Standard Administration Time Frames. Routine medications shall be administered within a one-hour window before or after the scheduled time (e.g., 8:00 AM dose given between 7:00 AM and 9:00 AM). Critical medications shall be administered at the exact time ordered or within a more restrictive window as defined below. 2. Medications considered time-critical must be . within 60 minutes before or after the scheduled time, unless otherwise specified by the prescriber. Examples include: Insulin (rapid-acting), Anticoagulants (e.g., warfarin, heparin), Antibiotics with specific dosing intervals, Anti-seizure medications, Medications with short half-lives or requiring consistent blood levels. The P&P indicated, 5. Missed or Late Doses. If a medication is not administered within the allowable time frame: The nurse shall assess the situation.if necessary. The dose shall not be automatically .without an order, Documentation must include: Reason for delay or omission.actions taken.notifications made.During a review of the facility's P&P titled, Medication Administration, dated 2024, the P&P indicated, Medications shall be administered safely, accurately, and timely in accordance with physician orders, accepted standards of practice,.outcomes.(Cross-reference with F759)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 practice standard hygienic practices in the kitchen when two staff members failed to wear beard restraints (coverings designed to cover facial hair including beards, mustaches, and goatees in the food service) during food preparation. This deficient practice had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in 136 of 166 medically compromised residents receiving meals from the kitchen.Findings:During an observation on 4/22/ 2026, at 10:00 a.m., kitchen staff (AM Cook) was observed standing at the food preparation table with an uncovered beard approximately two to three inches in length around the chin while seasoning chicken on a baking sheet, without wearing a beard net or restraint. After placing the chicken in the oven, the AM [NAME] returned to the preparation table and began chopping fresh zucchini for the lunch meal. During the concurrent observation, the Assistant Dietary Supervisor, who had a beard spanning the jawline and sideburns approximately 0.5-1.0 inches in length, was assisting AM [NAME] in the kitchen preparation area without wearing a beard net or restraint.During a concurrent interview on 4/22/ 2026, at 10:00 a.m., with the Dietary Supervisor (DS), when inquiring regarding the practice of wearing beard restraints DS stated, I have them wear it during service but not during prep. [NAME] restraints were not observed at the kitchen entrance where hair nets are routinely provided. Upon inquiring about the location and accessibility of beard restraints DS went into her office located in the opposing corner of the main kitchen entrance, reached underneath a desk, and pulled out cardboard box which contained a clear plastic bag filled with beard nets.During a follow-up interview with DS on 4/22/2026 at 2:15 p.m., DS stated that restraints should be treated in the same regard as hair nets to prevent hair from contacting food which can act as both physical and biological contaminant. During a review of facility's policy and procedure (P&P) titled Personal Hygiene, Personnel Permitted and Appearance in Food and Nutrition Service Department (undated), the P&P indicated all employees must wear hair restraints to prevent the contamination of food, equipment, or utensils. The P&P indicated beards, sideburns, and mustaches that are not closely cropped and neatly trimmed shall be covered.During a review of the 2022 FDA Food Code section 2-402.11, indicated that food employees shall wear hair coverings, including nets or beard restraints that are designed and worn to effectively keep hair from contacting exposed food, clean equipment and utensils.During a review of the Code of Federal Regulations, Title 21, Section 11.10 (b)(6), indicated Wearing, where appropriate, in an effective manner, hair nets, headbands, caps, beard covers, or other effective hair restraints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056433	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vermont Healthcare Center	22035 S. Vermont Avenue Torrance, CA 90502

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure clinical weight records were complete and accurate, and failed to identify and verify the weight loss documented in the medical record for one of six sampled residents (Resident 4) reviewed for nutritional status. This failure placed the resident at risk for not receiving timely clinical evaluation and intervention.Findings:During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. The admission Record indicated Resident 4 with diagnoses including chronic respiratory failure (any condition that affects breathing function and result in lungs not functioning properly), dependence on respirator (ventilator- a machine for artificial breathing), and atrial fibrillation (irregular heart rate that can cause poor blood flow).During a review of Resident 4's Minimum Data Set (MDS- a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 4's cognitive (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 4 was dependent on staff with oral hygiene, toileting hygiene, showering, and personal hygiene.During a review of Resident 4's Vital and Weight Summary, for the year 2026, the summary indicated following weights and reflected a total loss of 50.85% loss from 3/6/2026 to 3/30/2026:On 2/11/2026, Resident 4 weighed 200 pounds (lbs- a unit measure for weight).On 03/06/2026, Resident 4 weighed 199 lbs.On 03/30/2026, Resident 4 weighed 97.8 lbs.During a concurrent interview and record review on 04/23/2026 at 8:10 a.m. with Registered Nurse Supervisor (RNS) 1, Resident 4's Vital and Weight Summary, for the year of 2026 was reviewed. RNS 1 stated there was no documentation regarding the weight loss recorded on 3/30/2026, no recheck weight was obtained, and no follow-up was completed. RNS 1 stated the weight change represented a change of condition: however, no Change of Condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional status which without immediate intervention, may result in complications or death) assessment was completed, the attending physician was not notified, and no follow- up was initiated with the Registered Dietitian. RNS 1 also stated that sufficient time had elapsed to correct the weight if it had been a documentation error.During an interview on 4/23/2026 at 11:39 a.m. with RNS 1, RNS 1 stated the facility obtained Resident 4's weight on 4/23/2026, which was documented as 195 lbs.During an interview on 4/24/2026 at 3:38 p.m. with the Director of Nursing (DON), the DON stated staff should have reassessed Resident 4's weight immediately to verify the accuracy of the documented measurement. The DON stated that if the weight was confirmed to be accurate, a Change of Condition assessment should have been completed, and interventions should have been initiated and addressed promptly to ensure early intervention.During a review of the facility's policy and procedure (P&P), titled Weight Assessment and Intervention, dated 2024, the P&P indicated any weight change of 5% or more since the last weight assessment will be retaken for confirmation. If the weight is verified, nursing will immediately notify the Dietitian in writing. Verbal notification must be confirmed in writing. Inaccuracies will be corrected once confirmed by 2 licensed nurses.During a review of the facility's P&P, titled Charting and Documentation, dated 2024, the P&P indicated the documentation in the medical record will be complete, and accurate.During a review of the facility's P&P, titled Weight Change Protocol, undated, the P&P indicated early identification of a weight problem and possible cause(s) can minimize complications, assessment of residents experiencing weight changes should be completed in a timely manner. The P&P also indicated residents will be weighed monthly and weekly for those deemed to be at high risk for weight changes or according to the facility's policies.