STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056435	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hyde Park Healthcare Center	6520 West Blvd. Los Angeles, CA 90043

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure one of 17 sampled residents (Resident 167) participated in care plan meetings. This deficient practice violated Resident 167's rights to be fully informed of the resident's plan of care and had the potential to result in delay of care and services. Findings: During a review of Resident 167's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 167 was admitted to the facility on [DATE]. Resident 167's diagnoses included cerebral infarction (also known as stroke, the death of brain tissue due to a lack of blood flow), dysphagia (difficulty swallowing), and liver cirrhosis (a condition where healthy liver tissue is replaced by scar tissue, leading to impaired liver function). During a review of Resident 167s Minimum Data Assessment ([MDS] - a resident assessment tool), dated 6/15/2025, the MDS indicated, Resident 167 had the ability to express ideas and wants and the ability to understand others. The MDS indicated, Resident 167 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated, Resident 167 wants to participate in assessment and goal setting. During an interview on 6/24/2025 at 10:09 a.m., with Resident 167, Resident 167 stated she never had any meeting with the facility staff about her condition. Resident 167 stated she would like to meet the facility staff so they could discuss her list of medications. During a concurrent interview and record review on 6/25/2025 at 9:54 a.m., with the Social Service Director (SSD), Resident 167's Multidisciplinary Care Conference Note, dated 6/12/2025, was reviewed. The SSD stated the Multidisciplinary Care Conference Note, dated 6/12/2025, was not completed and there were no documentation that Resident 167 or her representative attended the care conference meeting. The SSD stated it is a standard of practice for the interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) to conduct a care plan meeting with the resident or his/her legal representative within 24-48 hours to discuss facility's plan of care. The SSD stated it was a violation of resident rights for not allowing the resident or her representative to participate in care planning process. (continued on next page)

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

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/25/2025 at 10:30 a.m., with the Minimum Data Set Nurse, the MDSN stated it was important to have a conference meeting with the resident or her representative so they could better meet the needs of the resident. During an interview on 6/25/2025 at 2:01 p.m., with the Director of Nursing, the DON stated it was important for the resident or her representative to be involved in the care plan meeting for them to share what was going on with the resident prior to the admission to the facility, to discuss discharge planning and for continuity of care. During a review of the facility's policy and procedure (P&P) titled, Care Plan Conference, dated 12/2016, the P&P indicated, It is the policy of the facility to provide each resident, resident's family, surrogate or representative a medium to held a care conference to meet and discuss the progress, needs and goals of care. The P&P indicated to document the care plan conference in the care conference meeting notes and include the summary of the meeting and list of attendees. During a review of the facility's P&P titled, Exercise of Resident Rights, dated 11/2017, indicated the facility protects and promotes the rights of each resident.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure a foley catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage) privacy drainage bag was provided for one of one sampled resident (Resident 20). This deficient practice had the potential for Resident 20 to feel embarrassed. Findings: During a review of Resident 20's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 20 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 20's diagnoses included benign prostatic hyperplasia (enlargement of the prostate), other specified diseases of bladder (a muscular, hollow organ in the lower abdomen that stores urine until it is eliminated from the body) and metabolic encephalopathy (a change in how your brain works due to an underlying condition). During a review of Resident 20's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 5/27/2025, the MDS indicated, Resident 20 had the ability to express ideas and wants and ability to understand others. The MDS indicated, Resident 20 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated, Resident 20 had indwelling catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage). During a concurrent observation and interview on 6/25/2025 at 9:38 a.m., with Registered Nurse 1 (RN 1) in Resident 20's room, Resident 20 was lying in bed. RN 1 stated, Resident 20's foley catheter drainage bag with urine was exposed, and no privacy bag was applied. RN 1 stated it is a standard of practice to put a drainage privacy bag for all residents with foley catheter. RN 1 stated Resident 20 would feel embarrassed that could possibly affect his quality of life by not having a foley catheter drainage privacy bag. RN 1 stated the privacy bag could also serve as a protection to prevent any damage of the drainage bag. During an interview on 6/25/2025 at 9:58 a.m., with the Director of Nursing (DON), the DON stated it is the responsibility of the licensed nursing staff to put privacy bag to promote resident's dignity. During a review of the facility's policy and procedure (P&P) titled, Resident Dignity and Personal Privacy, dated 12/2016, the P&P indicated, The facility provides care for residents in a manner that respects and enhance each resident's dignity, individuality, and right to personal privacy.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: 1. Ensure PRN (as needed) orders for Zyprexa (antipsychotic medications used to treat mental illness) were limited to a 14-day duration between 3/6/25 and 4/16/25 in one of five residents sampled for unnecessary medications (Resident 118.) 2. Monitor and document the target behavior of inability to relax and adverse effects (unwanted or dangerous side effects of medication) related to the use of Ativan (an anti-anxiety medication used to treat mental illness) in the Medication Administration Record (MAR - a record of all medication administration and monitoring done for a resident) in one of five residents sampled for unnecessary medications (Resident 13.) The deficient practices of failing to limit PRN orders for antipsychotic medications to 14-days and monitor target behaviors and adverse effects related to the use of psychotropic medications (medications that affect brain activities associated with mental processes and behavior) increased the risk that Residents 13 and 118 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 118 ' s admission Record (a document containing a resident ' s diagnostic and demographic information), dated 6/11/25, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including: bipolar disorder (a mental health condition that causes a person to experience extreme mood swings.) A review of Resident 118 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 5/16/25, indicated he had the capacity for medical decision making. During a review of Resident 118 ' s MAR for March 2025 indicated from 3/6/25 to 3/30/25, Resident 118 had an active order for Zyprexa 5 milligrams (mg - a unit of measure for mass) by mouth every six hours as needed for agitation, a period of 24 days. During a review of Resident 118 ' s MAR for March and April 2025 indicated from 3/31/25 to 4/16/25, Resident 118 had an active order for Zyprexa 5 mg by mouth every six hours as needed for manic depressive behavior with agitation related to schizophrenia (a mental illness characterized by hearing or seeing things that are not there or believing things that are not true), a period of 16 days. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/25 at 1:06 PM with the Director of Nursing (DON), the DON stated the facility failed to limit the duration of Resident 118's PRN Zyprexa to 14 days between 3/6/25 and 4/16/25. The DON stated PRN antipsychotics must be limited to 14 days only as their rationale for use may have changed within that time. The DON stated failing to limit PRN antipsychotics to 14 days increased the risk that Resident 118 may have received Zyprexa for longer than needed leading to adverse effects related to antipsychotic medications such as movement disorders, sedation, dry mouth, and falls with injury. During a review of Resident 13 ' s admission Record (a document containing a resident ' s diagnostic and demographic information), dated 6/26/25, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including: dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life.) During a review of Resident 13 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 5/9/25, indicated he did not have the capacity to make decisions or make needs known. During a review of Resident 13 ' s MAR for May and June 2025 indicated from 5/25/26 to 6/8/25, Resident 13 was prescribed Ativan 1 milligram (mg - a unit of measure for mass) by mouth every six hours for anxiety manifested by inability to relax. Further review of the MAR indicated there was no monitoring or documentation being conducted to record or quantify incidences of inability to relax or how frequently Resident 13 experienced adverse effects related to the use of Ativan. During a review of Resident 13 ' s Order Summary Report (a summary of all active physician orders), dated 6/26/25, indicated there were no physician orders to monitor for the behavior of inability to relax or adverse effects related to the use of Ativan. During a review of Resident 13 ' s available, undated care plans (resident-specific plans of care developed to address a specific problem or resident need) indicated there were no care plans addressing Resident 13 ' s diagnosis of anxiety (a mental illness characterized by constant worries persistent enough to interfere with everyday life), behavior of inability to relax, or the use of Ativan. During an interview on 6/26/25 at 1:15 PM with the Director of Nursing (DON), the DON stated the facility failed to create a comprehensive care plan regarding a diagnosis of anxiety with behavior of inability to relax related to the use of Ativan for Resident 13. The DON stated the facility failed to monitor Resident 13 for behaviors of inability to relax or adverse effects related to the use of Ativan in the resident's MAR. The DON stated failing to create care plans and monitor adverse effects and behaviors related to the use of psychotropic medications doesn't allow the resident's care team to make a fair evaluation as to whether the benefits of the medication continue to outweigh the risks. The DON stated this increased the risk that Resident 13 may have received Ativan for longer than is necessary possibly leading to a diminished quality of life. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy Psychoactive Medication Management, dated July 2017, indicated . Based on a comprehensive assessment of a resident, the facility must ensure that . PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication . The Medication Administration Record (MAR) will be used by nursing staff to document the frequency of behaviors, adverse reactions, and resident responses on each shift. The following information should be included in the MAR monitoring . behaviors being monitored every shift . possible adverse drugs reactions to be monitored .

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Report to the California Department of Public Health (CDPH- the state department responsible for public health in California) of a resident-to-resident altercation in a timely manner to CDPH for 2 of 3 sampled residents (Resident 118 and Resident 59). This deficient practice resulted in a delay in investigation by CDPH and placed Resident 2, Resident 3 and other residents at risk for further abuse. Findings: A. During a review of Resident 118's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 118 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), anxiety (feelings of worry, nervousness, or unease), polyosteoarthritis (a form of osteoarthritis that affects multiple joints in the body) and myalgia (muscle pain). During a review of Resident 118's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/8/2025, the MDS indicated Resident 118's cognitive skills were moderately impaired. The MDS indicated Resident 118 required partial assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 118's change of condition (COC) form, dated 6/8/2025, the COC indicated Resident 118 was found on the floor in his room at 7:30 a.m. The COC indicated Resident 118 stated his roommate had tripped him. The COC indicated Resident 59 denied tripping Resident 118. B. During a review of Resident 59's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 59 was admitted on [DATE] with diagnoses which included abnormalities of gait and mobility (a change in a person's walking pattern), psychosis, muscle wasting and atrophy and lack of coordination. During a review of Resident 59's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 5/10/2025, the MDS indicated Resident 59's cognitive skills were moderately impaired. The MDS indicated Resident 59 required partial assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review, on 6/26/2025, at 1:47 p.m., with the Director of Nursing (DON), the DON stated Resident 118 called the facility from the hospital and stated Resident 59 had tripped him. The DON stated she did not know the alleged altercation occurred on 6/8/2025. The DON stated the facility reported the allegation to CDPH on 6/10/2025. The DON stated the time frame for reporting abuse allegations was 2 hours. The DON stated the risk of not reporting in a timely manner could result in Obviously getting some sort of deficiency. During a concurrent interview and record review, on 6/26/2025, at 3:45 p.m., with the Assistant Administrator (Asst Admin), the Asst Admin stated Resident 118 had called him on 6/10/2025 stating Resident 59 had pushed him. The Asst Admin stated the COC indicated the allegation occurred on 6/8/2025. The Asst Admin stated he was not informed of the allegation on 6/8/2025. The Asst Admins stated the allegation should had been reported within 2 hours. The Asst Admin stated the risk of not reporting in a timely manner could result in further abuse and an unsafe environment. During a review of the facility's policy and procedures (P&P),titled Abuse and Neglect Prohibition Policy, dated 6/2022, the P&P indicated Upon receiving information concerning a report of suspected or alleged abuse, mistreatment, neglect, or exploitation, the Administrator or designee will perform the following: All alleged violations- immediately but not later than 2 hours if the alleged violation involves abuse or results in serious bodily injury.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Transmit the Discharge Minimum Data Set ([MDS]- a resident assessment tool) Assessment within 14 days after completion to Center of Medicare and Medicaid Services (CMS) for one of one sampled resident (Resident 15). This deficient practice had the potential to result in billing error and inaccurate data on resident care needs. Findings: During a review of Resident 15's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 15 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 15's diagnoses included metabolic encephalopathy (a change in how your brain works due to an underlying condition), epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures), and chronic obstructive pulmonary disease ([COPD] - a chronic lung disease causing difficulty in breathing). During a review of Resident 15's MDS assessment, dated 3/9/2025, the MDS indicated, Resident 15's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decision). The MDS indicated, Resident 15 was totally dependent (helper does all of the effort) from staff with toileting hygiene, lower body dressing, and personal hygiene. During a review of the CMS MDS 3.0 NH Validation Report, dated 6/26/2025, the CMS MDS 3.0 NH Validation Report, indicated Resident 15's MDS assessment was completed late for more 14 days after the Assessment Reference Date ([ARD] - the specific date used as the endpoint of the observation period when assessing resident's condition). During a concurrent interview and record review on 6/26/2025 at 10:24 a.m., with the Minimum Data Set Nurse (MDSN), Resident 15's discharge MDS assessment, dated 3/9/2025, was reviewed. The MDSN stated Resident 15's discharge MDS assessment had not been transmitted to the CMS. The MDSN stated all MDS assessment should be submitted and transmitted to the CMS within 14 days from the ARD/discharge date . The MDSN stated it was important to submit and transmit Resident 15's discharge MDS assessment in a timely manner so the CMS would know the whereabout of the resident. The MDSN stated submitting late MDS assessment to the CMS would affect facility's staffing and quality measures. During an interview on 6/26/2025 at 10:42 a.m., with the Director of Nursing (DON), the DON stated the importance of submitting MDS assessment in a timely manner was for the plan of care of the resident. During a review of the facility's policy and procedure (P&P) titled, Minimum Data Set (MDS) Transmission and Validation Reports, dated 10/2023, the P&P indicated, MDS nurse/RN Assessment Coordinator will create a batch to be transmitted to IQIES according to the electronic medical record (EMR) and RAI guidelines.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, the facility failed to: 1. Complete and re-submit the Preadmission Screening and Resident Review ([PASARR - a tool to determine if the person had, or was suspected of having a mental illness, intellectual disability, or related condition) Level one (I) screening and refer to the appropriate state-designated authority for PASARR Level two (II) evaluation and determination for two of seven sampled residents (Resident 13 and Resident 46). This deficient practice had the potential to result in Resident 13 and 46 to not receive the appropriate medical treatments for mental illness diagnosis. Findings: A. During a review of Resident 13's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 13 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 13's diagnoses included metabolic encephalopathy (a change in how your brain works due to an underlying condition), dysphagia (difficulty swallowing), and dementia (a progressive state of decline in mental abilities). During a review of Resident 13's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 4/21/2025, the MDS indicated, Resident 13's cognitive (ability to think and reason) skills for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated, Resident 13 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 13's Order Summary Report (a document containing active orders), dated 6/24/2025, the Order Summary Report indicated, the physician placed a telephone order on 6/12/2025 for Resident 13 to start on Lorazepam (drug to relieve anxiety) 1 milligram ([mg) - metric unit of measurement, used for medication dosage and/or amount) by mouth one tablet by mouth every six hours as needed for anxiety disorder (a mental health condition characterized by excessive, persistent, and irrational worry or fear that can interfere with daily life) manifested by inability to relax, for 14 days. During a review of Resident 13's Psychiatric Evaluation, dated 4/30/2025, indicated Resident 13 had diagnosis of anxiety disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/25/2025 at 1:28 p.m., with the Director of Nursing (DON), Resident 13's PASARR Level 1 screening completed by General Acute Care Hospital (GACH) on 2/3/2025, was reviewed. The DON stated the PASARR Level 1 screening indicated, Resident 13 had no serious mental illness diagnosis and was not prescribed psychotropic medication (Any drug that affects brain activities associated with mental process and behavior). The DON stated the PASARR Level 1 screening also indicated, Resident 13's case was closed, and a Level II mental health evaluation was not required. The DON stated the facility should have completed and resubmitted a new PASARR Level I for Resident 13 to indicate his diagnosis of anxiety disorder. The DON stated Lorazepam is considered as psychotropic drug classified as anti-anxiety medication. The DON stated it would be in the best interest of Resident 13 to be referred to State mental health agency so they could evaluate and review the mental health services he required. During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review, dated 12/2022, the P&P indicated, The facility will comply with all state and federal regulations to ensure appropriate placement and services for PASARR-identified individuals. During a review of PASRR reference manual, dated 2/2023, the PASRR reference manual indicated, An additional requirement has been added for NF's to promptly notify the state mental health and/or intellectual or developmental disability authority, as applicable, if there is a significant change in the physical or mental condition of an individual who is mentally ill or has an intellectual or developmental disability. This would warrant a re-evaluation to determine if a NF is still the most appropriate setting and/or if the individual could benefit from specialized services for his/her mental illness or intellectual disability. B. During a review of Resident 46's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 46 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder ((a mood disorder that causes a persistent feeling of sadness and loss of interest), bradycardia (slow heart rate) and sepsis (a life-threatening blood infection). During a review of Resident 46's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/15/2025, the MDS indicated Resident 46's cognitive skills were moderately impaired. The MDS indicated Resident 46 required partial assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 46's Level 1 PASARR application, dated 6/5/2025, the PASARR indicated Resident 46 did not require a Level 2 PASARR due to denying Resident 46 had a mental health disorder. During a concurrent interview and record review, on 6/26/2025, at 1:47 p.m., with the Director of Nursing (DON), the DON stated PASARRs was to be completed before or within 24 hours of a resident's admission. The DON stated she could process a resident's PASARR, but the facility hadn't given her access to do so. The DON stated Resident 46 had a diagnosis of schizophrenia and depression. The DON stated Resident 4's Level 1 PASARR indicated Resident 46 did not have a mental health condition. The DON stated a Level 1 PASARR should have been resubmitted with Resident 46's accurate diagnoses. The DON stated the risk of not resubmitting a PASARR for a resident could result in not providing the proper mental health services a resident may need. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening and Resident Review, dated 12/2022, the P&P indicated, The facility will comply with all state and federal regulations to ensure appropriate placement and services for PASARR-identified individuals.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to: 1. Submit a Pre-admission Screening and Record Review (PASARR) for one of four sampled residents (Resident 47). This deficient practice had the potential to result in a delay of necessary care and mental health services. Findings: During a review of Resident 47's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 46 was admitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (feelings of worry, nervousness, or unease) and other persistent mood disorders. During a review of Resident 47's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 5/12/2025, the MDS indicated Resident 47's cognitive skills were severely impaired. The MDS indicated Resident 47 required maximal assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review, on 6/26/2025, at 1:47 p.m., with the Director of Nursing (DON), the DON stated PASARRs was to be completed before admission or if not completed prior to admission, the facility would screen a resident within 24 hours. The DON stated she could process a resident's PASARR but the facility hadn't given her access to do so. The DON stated Resident 47 had a diagnosis of schizophrenia, depression, anxiety and other mood disorders. The DON stated Resident 47's should have had a Level 1 PASARR submitted upon his admission of May 2025. The DON stated the risk of not submitting a PASARR for a resident could result in not providing the proper mental health services a resident may need. During a review of the facility's policy and procedures (P&P), titled Pre-admission Screening and Resident Review, dated 12/2022, the P&P indicated The PASRR Level 1 screening is required for all potential skilled nursing facility (SNF) residents.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Develop a baseline care plan for one of 17 sampled residents (Resident 167). This deficient practice had the potential for Resident 167 to not receive appropriate care and treatment specific to her needs. Findings: During a review of Resident 167's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 167 was admitted to the facility on [DATE]. Resident 167's diagnoses included cerebral infarction (also known as stroke, the death of brain tissue due to a lack of blood flow), dysphagia (difficulty swallowing), and liver cirrhosis (a condition where healthy liver tissue is replaced by scar tissue, leading to impaired liver function). During a review of Resident 167s Minimum Data Assessment ([MDS] - a resident assessment tool), dated 6/15/2025, the MDS indicated, Resident 167 had the ability to express ideas and wants and the ability to understand others. The MDS indicated, Resident 167 required moderate assistance (helper does less than half the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. During a concurrent interview and record review on 6/25/2025 at 10:21 a.m., with the Social Service Director (SSD), Resident 167's clinical records were reviewed. The SSD stated the facility staff did not develop a baseline care plan for Resident 167. The SSD stated each member of the interdisciplinary team ([IDT] - team members from different disciplines who come together to discuss resident care) was responsible in creating a baseline care plan within 24 to 48 hours upon residents admission to the facility. The SSD stated baseline care plan serves as a communication tool that reflects resident's condition and facility staff initial intervention for the resident. During an interview on 6/25/2025 at 10:36 a.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated baseline care plan should be developed upon admission in order to provide the needs of the resident. During an interview on 6/25/2025 at 2:01 p.m., with the Director of Nursing (DON), the DON stated it was important to develop a baseline care plan so the facility staff could coordinate the care and services to the resident. During a review of the facility's policy and procedure (P&P) titled, Baseline Plan of Care, dated 12/2016, the P&P indicated, It is the policy of the facility to provide each resident with an interim (initial) plan of care developed within 48 hours of admission that addresses identified risk areas and resident's initial individual needs. The P&P indicated the interdisciplinary team develops the interim plan of care based on information received from the referring facility, physician's orders, resident and family interviews, clinical screens and assessments, and other information received during the admission process.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Develop a comprehensive plan of care (resident-specific plans of care developed to address a specific problem or resident need) to address a diagnosis of anxiety (a mental illness characterized by constant worries persistent enough to interfere with everyday life) and behaviors of inability to relax related to the use of Ativan (an anti-anxiety medication used to treat mental illness) in one of five residents sampled for unnecessary medications (Resident 13.) The deficient practices of failing to create a comprehensive care plan to address Resident 13 ' s diagnosis of anxiety and behavior of inability to relax related to the use of psychotropic medications (medications that affect brain activities associated with mental processes and behavior) increased the risk that Residents 13 could have experienced adverse effects related to psychotropic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in his mental or physical condition or functional or psychosocial status. 2. Ensure a schizophrenia care plan was developed for one of four sampled residents (Resident 46). This deficient practice had the potential to result in a delay in delivery of care and services. Findings: A. During a review of Resident 13 ' s admission Record (a document containing a resident ' s diagnostic and demographic information), dated 6/26/25, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including: dementia (the loss of cognitive function, including memory, thinking, and reasoning, that interferes with daily life.) During a review of Resident 13 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 5/9/25, indicated he did not have the capacity to make decisions or make needs known. During a review of Resident 13 ' s MAR for May and June 2025 indicated from 5/25/26 to 6/8/25, Resident 13 was prescribed Ativan 1 milligram (mg - a unit of measure for mass) by mouth every six hours for anxiety manifested by inability to relax. Further review of the MAR indicated there was no monitoring or documentation being conducted to record or quantify incidences of inability to relax or how frequently Resident 13 experienced adverse effects related to the use of Ativan. During a review of Resident 13 ' s Order Summary Report (a summary of all active physician orders), dated 6/26/25, indicated there were no physician orders to monitor for the behavior of inability to relax or adverse effects related to the use of Ativan. During a review of Resident 13 ' s available, undated care plans indicated there were no care plans addressing Resident 13 ' s diagnosis of anxiety, behavior of inability to relax, or the use of Ativan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/26/25 at 1:15 PM with the Director of Nursing (DON), the DON stated the facility failed to create a comprehensive care plan regarding a diagnosis of anxiety with behavior of inability to relax related to the use of Ativan for Resident 13. The DON stated the facility failed to monitor Resident 13 for behaviors of inability to relax or adverse effects related to the use of Ativan in the resident's MAR. The DON stated failing to create care plans and monitor adverse effects and behaviors related to the use of psychotropic medications doesn't allow the resident's care team to make a fair evaluation as to whether the benefits of the medication continue to outweigh the risks. The DON stated this increased the risk that Resident 13 may have received Ativan for longer than is necessary possibly leading to a diminished quality of life. B. During a review of Resident 46's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 46 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included schizophrenia (a mental illness that is characterized by disturbances in thought), major depressive disorder ((a mood disorder that causes a persistent feeling of sadness and loss of interest), bradycardia (slow heart rate) and sepsis (a life-threatening blood infection). During a review of Resident 46's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/15/2025, the MDS indicated Resident 46's cognitive skills were moderately impaired. The MDS indicated Resident 46 required partial assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a concurrent interview and record review, on 6/26/2025, at 1:47 p.m., with the Director of Nursing (DON), the DON stated care plans were to be initiated upon admission or if a change of condition occurred. The DON stated care plans were required for residents with a diagnosis of schizophrenia. The DON stated there was no care plan for Resident 46's schizophrenia diagnosis. The DON stated the risk of not completing a care plan for a resident could result in improper care. The DON stated, We need to have an individualized care plan to deliver the proper care to a resident. A review of the facility ' s policy Psychoactive Medication Management, dated July 2017, indicated .An individualized care plan will be developed for residents with behavioral and psychoactive medication. The plan will include interventions for: The mood or behavior problem and its manifestations will be entered on the care plan with the side effects of the drugs, non-drug interventions and monitoring methods .

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to: 1. Ensure a low air loss mattress (a specialized type of medical air mattress designed to prevent and treat pressure injuries (bedsores) by reducing moisture and heat buildup on the skin) was provided for one of four sampled residents (Resident 46). This deficient practice had the potential to result in further skin breakdown. Findings: During a review of Resident 46's face sheet (front page of the chart that contains a summary of basic information about the resident), the face sheet indicated Resident 46 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses which included Stage 4 pressure ulcer of the right buttock(a wound over bony prominences characterized by full-thickness tissue loss, exposing muscle, bone, or tendon), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), bradycardia (slow heart rate) and sepsis (a life-threatening blood infection). During a review of Resident 46's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/15/2025, the MDS indicated Resident 46's cognitive skills were moderately impaired. The MDS indicated Resident 46 required partial assistance with activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a record review of Resident 46's physician orders, dated 6/24/2025, the physician order stated Resident 46 was to have a low air loss mattress. During an observation on 6/26/2025, at 9:14 a.m., Resident 46 was observed laying on a regular mattress. During a concurrent observation and interview, on 6/26/2025 at 1:47 p.m., with the Director of Nursing (DON), the DON stated the purpose of low air loss mattresses was to avoid skin breakdown for residents with pressure ulcers. The DON stated residents with pressure ulcers were required to have low air loss mattresses. The DON stated no air loss mattresses had been ordered for a resident within the last 2 months. The DON stated Resident 46 did not have a low air loss mattress as ordered. The DON stated the risk of not providing a resident a low air loss mattress as ordered could result in wound discoloration. During a review of the facility's policy and procedures, titled Pressure Reducing Mattresses, dated 4/2022, the P&P indicated, Pressure reducing support surfaces are a type of durable medical equipment (DME) used for the care of pressure sores, also known as pressure ulcers. and A specialty mattress will be obtained for pressure relief of residents that have pressure injury or at risk for pressure injury.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** B. During a review of Resident 56's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 56 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 56's diagnoses included metabolic encephalopathy (a change in how your brain works due to an underlying condition), dementia (a progressive state of decline in mental abilities), and nicotine (substance found in tobacco products). During a review of Resident 56's History and Physical (H&P), the H&P indicated, Resident 56 could make needs known but did not have the capacity to consent. During a review of Resident 56's annual Minimum Data Assessment ([MDS] - a resident assessment tool), dated 1/14/2025, the MDS indicated, Resident 56's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 56 required supervision (helper provides verbal cues) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. The MDS indicated, Resident 56 had current tobacco use. During a concurrent interview and record review on 6/26/2025 at 10:06 a.m., with the Minimum Data Set Nurse (MDSN), Resident 56's clinical records were reviewed. The MDSN stated Resident 56 had an initial Smoking and Safety assessment completed on 1/11/2025 but did not have a quarterly (every 3 months) Smoking and Safety assessment completed. The MDSN stated she was responsible in completing and updating the Smoking and Safety assessment for all residents identified as smokers. The MDSN stated the Smoking and Safety assessment is a tool to identify if resident could smoke independently, supervised by a facility staff and resident's ability to smoke safely. The MDSN stated it was important to complete and update the resident's Smoking and Safety assessment to ensure appropriate interventions are implemented for the safety of the residents and staff. During an interview on 6/26/2025 at 10:35 a.m., with the Director of Nursing (DON), the DON stated it was important to complete and update the Smoking and Safety assessment to determine if there was a change in the plan of care of the resident. During a review of the facility's policy and procedure (P&P) titled, Residents Smoking Policy, dated 6/2022, the P&P indicated, The facility shall establish and maintain safe resident smoking practices. The P&P indicated documentation of smoking will be assessed and documented in the smoking assessment. During a review of the facility's P&P titled, Minimum Data Set (MDS) Care Area Assessment (CAA), dated 10/2023 indicated the Care Area Assessment is part of the initial and periodic assessments for all patients used to develop, review, and revise the plan of care that will be used to provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Based on interview and record review, the facility failed to: 1. Ensure the fire extinguisher on the smoking patio was accessible for use in case of an emergency. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	This deficient practice had the potential to result in injury to residents on the smoking patio in the event of a fire. 2. Ensure quarterly smoking assessment was completed for one of one sampled resident (Resident 56). This deficient practice had the potential to place Resident 56 at risk for injury and inadequate care planning. Findings: A. During a concurrent observation and interview on 6/24/2025 at 1:15 p.m. with the Activity Assistant (AA) on the smoking patio, the fire extinguisher was observed in a locked box. The AA stated she did not have the key. The maintenance supervisor has the key. The AA stated if there is a fire, the extinguisher is not accessible. The AA further stated she would have run to the kitchen to get a fire extinguisher in the event of a fire emergency. The AA stated if there is a fire residents could be injured because there isn't a fire extinguisher nearby to use.

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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 interview and record review, the facility failed to: 1. Ensure an appointment for urology (branch of medicine that focuses on surgical and medical diseases of the urinary system and the reproductive organs) evaluation/referral was completed for one of one sampled resident (Resident 20). This deficient practice had the potential to result in the delay of necessary care and services. Findings: During a review of Resident 20's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 20 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 20's diagnoses included benign prostatic hyperplasia (enlargement of the prostate), other specified diseases of bladder (a muscular, hollow organ in the lower abdomen that stores urine until it is eliminated from the body) and metabolic encephalopathy (a change in how your brain works due to an underlying condition). During a review of Resident 20's Minimum Data Assessment ([MDS] - a resident assessment tool), dated 5/27/2025, the MDS indicated, Resident 20 had the ability to express ideas and wants and ability to understand others. The MDS indicated, Resident 20 was totally dependent (helper does all of the effort) from staff with oral hygiene, toileting hygiene, and personal hygiene. The MDS indicated, Resident 20 had indwelling catheter (a flexible plastic tube inserted into the bladder to provide continuous urinary drainage). During a review of Resident 20's General Acute Care Hospital (GACH) discharge order, dated 5/23/2025, the GACH discharge order indicated to refer Resident 20 to urology for urodynamics and cystogram (both diagnostic tests used to evaluate the lower urinary tract) related to history of urinary tract infection ([UTI] - an infection in the bladder/urinary tract). During a review of Resident 20's Progress Notes, dated 5/23/2025, the Progress Notes indicated, Resident 20 will need a referral to urology. During a concurrent interview and record review on 6/25/2025 at 10:58 a.m. with the Minimum Data Set Nurse (MDSN), Resident 20's clinical records were reviewed. The MDSN stated the licensed nursing staff was responsible for scheduling urology appointment. The MDSN stated the urology referral appointment for Resident 20 should have been made but was not. The MDSN stated it was important for Resident 20 to be seen by a urologist to evaluate the use of his foley catheter and to determine how long he would need it. The MDSN stated prolong use of foley catheter would result in urine infection possibly leading to sepsis (a life-threatening blood infection) that would likely require hospitalization. During an interview on 6/25/2025 at 2:05 p.m., with the Director of Nursing (DON), the DON stated it was important to follow the recommendation from the GACH for Resident 20 to be referred to a urologist. The DON stated she was not really sure what would be the worst complication of UTI. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Referrals to Outside Agencies, dated 8/2017, the P&P indicated, Referrals may be made to outside agencies to meet the physical or psychosocial needs of the resident. During a review of the facility's P&P titled, Preventing Catheter Related Urinary Tract Infection (UTI) dated 8/2017, the P&P indicated it is the policy of the facility to ensure appropriate interventions are used for prevention of catheter related UTI.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure the initial and annual competency checklists were completed for one of four sampled employees (Certified Nurse Assistant [CNA] 3). This failure had the potential to negatively affect the residents' quality of care. Findings: During a review of CNA 3's employee personnel file, the employee personnel file did not indicate an initial competency checklist was completed upon hire (5/10/2023) and an annual competency checklist in May 2025. During an interview on 6/26/2025 at 3:04 pm with the Director of Staff Development (DSD), the DSD stated she could not provide documentation of CNA 3's initial competency checklist for 2023 and her annual competency checklist for 2025. The DSD stated CNA 3's initial competency checklist should have been completed on the day she was hired (5/10/2023) and her annual competency checklist should have been completed in May 2025. The DSD stated the purpose of completing initial and annual competency checklists is to make sure staff are up to date with their skills and to ensure staff perform their job effectively. The DSD stated residents could be affected because CNAs might not be able to provide care to their full potential. During a record review of the facility's P&P titled, Competency Evaluation, revised 7/2019, the P&P indicated, Upon hire, each nursing staff's competency will be reviewed and completed by the end of the probationary period .Annually, each employee's competency will be reviewed during performance evaluation review.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to maintain complete records of non-narcotic (medications other than those controlled for an increased risk of abuse) destruction logs by failing to have a licensed nurse and a witness sign the destruction logs in one of one inspected medication rooms (Station 1 Medication Room.) The deficient practice of failing to ensure a licensed nurse and witness sign off on the non-narcotic destruction logs increased the risk of drug diversion (any use of a medication for reasons other than those intended by the prescriber) or accidental exposure to the facility ' s residents possibly leading to medical complications. Findings: During an observation on 6/25/25 at 11:32 AM of Station 1 Medication Room, the non-narcotic medication destruction logs were found to be kept in a three-ring binder inside the medication room. During a review of the available Facility Medication Destruction Form records dating from 3/6/25 to present indicated none of the available records contained signatures from licensed staff, witnesses, or any other indication of who was responsible for completing the medication destruction. Further review of the available records indicated that many of the entries were also undated. During an interview on 6/25/25 at 12:08 PM with the Director of Nursing (DON), the DON stated the non-narcotic destruction logs between 3/4/25 and 6/23/25 are incomplete as there are no signatures to determine which nurses completed the disposition. DON stated the nurses on the overnight shift who are responsible for performing the disposition failed to sign off any of the available logs after completing the destructions. The DON stated this increased the risk of medication diversion or accidental exposure of medication which could have unintended consequences on the residents possibly leading to medical complications. During a review of the facility ' s policy Disposal of Medication, revised July 2022, indicated .A non-controlled medication disposition log or form shall be used for documentation and shall be retained as per federal privacy and state regulations. The log shall contain the following information: . Date of disposition . Signatures of the required witnesses .

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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 respond to the consultant pharmacist ' s recommendation (monthly recommendations by a pharmacist concerning potential medication-related irregularities), dated 3/23/25, to limit PRN (as needed) orders for Zyprexa (antipsychotic medications used to treat mental illness) to a 14-day duration in one of five residents sampled for unnecessary medications (Resident 118.) The deficient practices of failing to respond to the consultant pharmacist ' s recommendation to limit PRN orders for antipsychotic medications to 14-days increased the risk that Resident 118 could have experienced adverse effects related to antipsychotic medication therapy, such as drowsiness, dizziness, constipation, or increased risk of fall, possibly leading to impairment or decline in his mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 118 ' s admission Record (a document containing a resident ' s diagnostic and demographic information), dated 6/11/25, indicated he was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including: bipolar disorder (a mental health condition that causes a person to experience extreme mood swings.) During a review of Resident 118 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 5/16/25, indicated he had the capacity for medical decision making. During a review of Resident 118 ' s MAR for March 2025 indicated from 3/6/25 to 3/30/25, Resident 118 had an active order for Zyprexa 5 milligrams (mg - a unit of measure for mass) by mouth every six hours as needed for agitation, a period of 24 days. During a review of Resident 118 ' s MAR for March and April 2025 indicated from 3/31/25 to 4/16/25, Resident 118 had an active order for Zyprexa 5 mg by mouth every six hours as needed for manic depressive behavior with agitation related to schizophrenia (a mental illness characterized by hearing or seeing things that are not there or believing things that are not true), a period of 16 days. During a review of the consultant pharmacist ' s recommendation, dated 3/23/35, indicated the pharmacist recommended to ensure Resident 118 ' s order for PRN Zyprexa was limited to a 14-day duration. Further review of the recommendation indicated the facility did not document a response to the pharmacist or that any additional action had been taken concerning the recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/25 at 1:06 PM with the Director of Nursing (DON), the DON stated the facility failed to limit the duration of Resident 118's PRN Zyprexa to 14 days between 3/6/25 and 4/16/25. The DON stated PRN antipsychotics must be limited to 14 days only as their rationale for use may have changed within that time. The DON stated the facility failed to respond to the consultant pharmacist ' s recommendation dated 3/23/25 to limit Resident 118 ' s PRN Zyprexa for 14 days. The DON stated failing to limit PRN antipsychotics to 14 days or respond to the pharmacist ' s recommendation increased the risk that Resident 118 may have received Zyprexa for longer than needed leading to adverse effects related to antipsychotic medications such as movement disorders, sedation, dry mouth, and falls with injury. During a review of the facility ' s policy Psychoactive Medication Management, dated July 2017, indicated . Based on a comprehensive assessment of a resident, the facility must ensure that . PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluated the resident for the appropriateness of that medication . During a review of the facility ' s policy Limited Drug Regimen Review, revised April 2018, indicated Review drug list with the pharmacist at the time of order . if there are any recommendations, contact physician and inform of why change in medication is indicated .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Three errors out of 26 opportunities contributed to an overall error rate of 11.54 % affecting two of four residents observed for medication administration (Resident 32 and Resident 40.). The errors noted were as follows: 1. Incorrect dose of calcium carbonate (a supplement) administered to Resident 32 2. Incorrect formulation of multivitamins (a supplement) administered to Resident 40 3. Incorrect dose of Seroquel (a medication used to treat mental illness) administered to Resident 40. The deficient practice of failing to administer medications in accordance with the physician ' s orders increased the risk that Residents 32 and 40 may have experienced medical complications possibly resulting in hospitalization. Findings: During an observation of medication administration on 6/25/25 at 8:08 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medications for Resident 32: 1. One tablet of calcium carbonate 750 milligrams (mg - a unit of measure for mass) During an observation on 6/25/25 at 8:22 AM, LVN 1 was observed offering calcium carbonate 750 mg tablet to Resident 32. Resident 32 was observed taking the medication by mouth with water. A review of Resident 32 ' s admission Record (a document containing diagnostic and demographic information), dated 6/25/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including paranoid schizophrenia (a mental illness characterized by seeing or hearing things that are not there.) A review of Resident 32 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 2/4/25, indicated she had the capacity to understand and make her own medical decisions. A review of Resident 32 ' s Order Summary Report (a monthly summary report of all active physician orders), dated 6/25/25, indicated Resident 32 ' s attending physician prescribed calcium carbonate 500 mg by mouth one time a day for supplement. During an observation of medication administration on 6/25/25 at 8:22 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medications for Resident 40: 1. One tablet of multivitamins with minerals (a supplement) 2. One tablet of Seroquel 50 mg. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/25/25 at 8:29 AM, LVN 1 was observed offering the multivitamin with minerals and Seroquel 50 mg tablets to Resident 40. Resident 40 was observed taking the medications by mouth with water. A review of Resident 40 ' s admission Record (a document containing diagnostic and demographic information), dated 6/25/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including schizophrenia (a mental illness characterized by seeing or hearing things that are not there.) A review of Resident 40 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 1/23/25, indicated she had the capacity for medical decision making. A review of Resident 40 ' s Order Summary Report (a monthly summary report of all active physician orders), dated 6/25/25, indicated Resident 40 ' s attending physician prescribed the following: 1. Multivitamin tablet (formulation without minerals) by mouth in the morning for supplement 2. Seroquel 50 mg to give one-half tablet by mouth every morning and at bedtime for schizophrenia manifested by delusional belief people trying to harm her. During an observation and concurrent interview on 6/25/25 at 9:29 AM with LVN 1, Resident 40's supply of Seroquel 50 mg was observed to be packaged in a bubble-pack with each bubble containing a full tablet. Further observation of Resident 40 ' s supply of Seroquel 50 mg revealed no tablets were pre-split and the pharmacy instructions labeled on the bubble pack indicated to give 1 (full) tablet by mouth twice daily with a fill date of 6/4/25. LVN 1 stated Resident 40's order for Seroquel 50 mg is to give one-half tablet daily. LVN 1 stated she administered the wrong dose by administering a full tablet rather than a half tablet. LVN 1 stated she failed to check the instructions on the order with the instructions on the pharmacy label to ensure they were correct. LVN 1 stated, if she had noticed the instructions were different, she would have called the physician to clarify the order and the pharmacy to determine if there was a dispensing error. LVN 1 stated giving a higher dose of Seroquel than ordered may result in medical complications from medication-related side effects which could lead to a decline in quality of life or hospitalization for Resident 40. LVN 1 stated she also administered the wrong dose of calcium carbonate tablets to Resident 32. LVN 1 stated Resident 32's dose of calcium carbonate is 500 mg, and she administered 750 mg. LVN 1 stated she also administered the wrong formulation of multivitamins to Resident 40. LVN 1 stated she administered the formulation containing minerals while Resident 40 ' s order specified the version without. LVN 1 stated it is important to check the products and dosages against the residents' orders prior to administering medication to ensure they match. LVN 1 stated giving the incorrect strengths and formulations of medications could lead to medical complications. During an interview on 6/25/25 at 11:43 AM with LVN 1, LVN 1 stated she contacted the pharmacy regarding Resident 40's Seroquel 50 mg order and determined the pharmacy never received a fax for the new order for Resident 40's Seroquel when the dose was recently decreased. LVN 1 stated this explains why the instructions on the pharmacy label differed from Resident 40's current order. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy Medication Administration - General Guidelines, dated March 2024, indicated . Prior to administration, the medication and dosage schedule on the resident ' s MAR shall be compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician ' s orders shall be checked for the correct dosage schedule . Medications shall be administered in accordance with written orders of the attending physician .

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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 ensure residents were free of significant medication errors by administering the incorrect dose of Seroquel (a medication used to treat mental illness) on 6/25/25 to one of four residents observed for medication administration (Resident 40.) The deficient practice of failing to administer medications in accordance with the physician ' s orders increased the risk that Resident 40 may have experienced medical complications possibly resulting in hospitalization. Findings: During an observation of medication administration on 6/25/25 at 8:22 AM with the Licensed Vocational Nurse (LVN 1), LVN 1 was observed preparing the following medication for Resident 40: 1. One tablet of Seroquel 50 mg. During an observation on 6/25/25 at 8:29 AM, LVN 1 was observed offering the Seroquel 50 mg tablet to Resident 40. Resident 40 was observed taking the medication by mouth with water. A review of Resident 40 ' s admission Record (a document containing diagnostic and demographic information), dated 6/25/25, indicated she was admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses including schizophrenia (a mental illness characterized by seeing or hearing things that are not there.) A review of Resident 40 ' s History and Physical (H&P - a record of a comprehensive physician ' s assessment), dated 1/23/25, indicated she had the capacity for medical decision making. A review of Resident 40 ' s Order Summary Report (a monthly summary report of all active physician orders), dated 6/25/25, indicated Resident 40 ' s attending physician prescribed the following: 1. Seroquel 50 mg to give one-half tablet by mouth every morning and at bedtime for schizophrenia manifested by delusional belief people trying to harm her. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and concurrent interview on 6/25/25 at 9:29 AM with LVN 1, Resident 40's supply of Seroquel 50 mg was observed to be packaged in a bubble-pack with each bubble containing a full tablet. Further observation of Resident 40 ' s supply of Seroquel 50 mg revealed no tablets were pre-split and the pharmacy instructions labeled on the bubble pack indicated to give 1 (full) tablet by mouth twice daily with a fill date of 6/4/25. LVN 1 stated Resident 40's order for Seroquel 50 mg is to give one-half tablet daily. LVN 1 stated she administered the wrong dose by administering a full tablet rather than a half tablet. LVN 1 stated she failed to check the instructions on the order with the instructions on the pharmacy label to ensure they were correct. LVN 1 stated, if she had noticed the instructions were different, she would have called the physician to clarify the order and the pharmacy to determine if there was a dispensing error. LVN 1 stated giving a higher dose of Seroquel than ordered may result in medical complications from medication-related side effects which could lead to a decline in quality of life or hospitalization for Resident 40. LVN 1 stated it is important to check the products and dosages against the residents' orders prior to administering medication to ensure they match. LVN 1 stated giving the incorrect strengths and formulations of medications could lead to medical complications. During an interview on 6/25/25 at 11:43 AM with LVN 1, LVN 1 stated she contacted the pharmacy regarding Resident 40's Seroquel 50 mg order and determined the pharmacy never received a fax for the new order for Resident 40's Seroquel when the dose was recently decreased. LVN 1 stated this explains why the instructions on the pharmacy label differed from Resident 40's current order. A review of the facility ' s policy Medication Administration - General Guidelines, dated March 2024, indicated .Prior to administration, the medication and dosage schedule on the resident ' s MAR shall be compared with the medication label. If the label and MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician ' s orders shall be checked for the correct dosage schedule . Medications shall be administered in accordance with written orders of the attending physician .

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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: 1. Store one unopened vial of latanoprost eye drops (a medication used to treat eye conditions) in the refrigerator according to the manufacturer's instructions affecting Resident 2 in one of two inspected medication carts (Station 2 Cart.) 2. Store two unopened Lantus insulin pens (a medication used to treat high blood sugar) in the refrigerator according to the manufacturer's instructions affecting Residents 30 and 216 in one of two inspected medication carts (Station 1 Cart.) The deficient practices of failing to store medications per the manufacturers ' requirements increased the risk that Residents 2, 20, and 216 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death. Findings: During a concurrent observation and interview on [DATE] at 11:24 AM of Station 2 Cart with the Licensed Vocational Nurse (LVN 2), the following medications were found either expired, stored in a manner contrary to their respective manufacturer ' s requirements, or not labeled with an open date as required by their respective manufacturer ' s specifications: 1. One unopened vial of latanoprost eye drops for Resident 2 was found stored in the medication cart at room temperature. According to the product labeling, unopened vials of latanoprost eye drops must be stored in the refrigerator. During a concurrent interview, LVN 2 stated the unopened latanoprost eye drops should be kept in the refrigerator before they are in use. LVN 2 stated not storing the eye drops in the refrigerator could cause them to not work as intended. LVN2 stated this may cause medical complications such as Resident 2's eyes to get worse, possibly resulting in hospitalization. During a concurrent observation and interview on [DATE] at 11:24 AM of Station 1 Cart with the Licensed Vocational Nurse (LVN 1), the following medications were found either expired, stored in a manner contrary to their respective manufacturer ' s requirements, or not labeled with an open date as required by their respective manufacturer ' s specifications: 1. One unopened Lantus insulin pen for Resident 216 was found stored in the medication cart at room temperature. According to the product labeling, unopened Lantus insulin pens must be stored in the refrigerator. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. One unopened Lantus insulin pen for Resident 30 was found stored in the medication cart at room temperature. According to the product labeling, unopened Lantus insulin pens must be stored in the refrigerator. During a concurrent interview, LVN 1 stated the Lantus pens for Residents 30 and 216 are unopened and stored at room temperature. LVN 1 stated unopened insulin pens are supposed to be stored in the refrigerator until they are opened. LVN 1 stated once they are opened, they are only good for 28 days and must be dated to know when to discard. LVN 1 stated, if they Lantus pens are stored or labeled improperly, they could become ineffective at controlling Resident 30 and 216's blood sugar possibly leading to medical complications and a decreased quality of life. A review of the facility ' s policy Storage of Medication, dated [DATE], indicated Medications and biologicals shall be stored safely, securely, and properly, following manufacturer ' s recommendations or those of the supplier . Medications requiring ' refrigeration ' . shall be kept in a refrigerator with a thermometer to allow temperature monitoring .

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure one of five sampled residents (Resident 38) had a Levetiracetam level (a blood test to check the amount of this drug in your body) completed every three months. This deficient practice had the potential to result in Resident 38 having a seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) if the levels were not in range. Findings: During a review of Resident 38's admission Record, the admission Record indicated Resident 38 was admitted to the facility on [DATE], with a readmission on [DATE]. Resident 38's diagnoses included hypertension (HTN-high blood pressure), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and epilepsy (a brain condition that causes recurring seizures). During a review of Resident 38's History and Physical (H&P), dated 1/2/2025, the H&P indicated Resident 38 had the capacity for medical decision making. During a review of Resident 38's Minimum Data Set (MDS - a resident assessment tool), dated 4/30/2025, the MDS indicated Resident 10 needed moderate assistance with toileting, showering, and dressing. During a review of Resident 38's Order Summary, dated 6/27/2025, the summary indicated on 2/27/2025 the physician entered an order for a Levetiracetam level the next lab day and every three months thereafter. During a review of Resident 38's care plan, dated 6/11/2025, the care plan indicated Resident 38 had a seizure disorder. The care plan further indicated the facility would monitor labs and report any sub therapeutic (below a desired range for effectiveness) or toxic (having the effect of poison) results to the physician. During a concurrent interview and record review on 6/27/2025 at 10:54 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 38's lab results were reviewed. LVN2 stated the Levetiracetam blood test was not completed. LVN2 stated the physician ordered the test to ensure the drug level is within normal limits. It will let the physician know if the medication dosage needs to be increased or decreased. If you don't know the levels, it could possibly be too low and result in the resident having a seizure.

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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: 1. Ensure the documentation was complete and x-ray result for one of one sampled resident (Resident 56) was accessible and filed in medical records. This deficient practice had the potential to place Resident 56 at risk of not receiving appropriate care and delay in communication among staff due to incomplete medical records. Findings: During a review of Resident 56's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated, Resident 56 was initially admitted to the facility on [DATE] and readmitted on [DATE]. Resident 56's diagnoses included metabolic encephalopathy (a change in how your brain works due to an underlying condition), dementia (a progressive state of decline in mental abilities), and nicotine (substance found in tobacco products). During a review of Resident 56's History and Physical (H&P), the H&P indicated, Resident 56 could make needs known but did not have the capacity to consent. During a review of Resident 56's annual Minimum Data Assessment ([MDS] - a resident assessment tool), dated 1/14/2025, the MDS indicated, Resident 56's cognitive (ability to think and reason) skills for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated, Resident 56 required supervision (helper provides verbal cues) from staff with oral hygiene, toileting hygiene, and upper and lower body dressing. During a review of Resident 56's Order Summary Report (a document containing active orders), dated 6/27/2025, the Order Summary Report indicated, the physician placed a telephone order on 6/16/2025 for Resident 56 to have x-ray of left leg and foot. During a concurrent interview and record review on 6/26/2025 at 10:08 a.m., with Licensed Vocational Nurse 1 (LVN 1), Resident 56's clinical records were reviewed. LVN 1 stated the physician of Resident 56 ordered a stat (immediately or without delay) x-ray on 6/16/2025 to evaluate the cause of pain and swelling on resident's left leg and foot. LVN 1 stated Resident 56's medical records were incomplete, and the left leg and foot x-rays results were not accessible. LVN 1 stated there was no documentation indicating the facility staff communicated with the physician of Resident 56's regarding the x-ray results and no evidence of follow up with the x-ray provider of what happened with the x-ray results. LVN 1 stated if it was not documented then it did not happen. During an interview on 6/27/2025 at 10:47 a.m., with the Director of Nursing (DON), the DON stated on 6/17/2025 she received the left leg and foot x-ray results of Resident 56 and gave it to one of the licensed nursing staff. The DON could not explain why the x-rays results were not available and accessible in resident's medical records. The DON stated she believed that the x-rays results were reported to Resident 56's physician but could not provide any documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056435	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hyde Park Healthcare Center	6520 West Blvd. Los Angeles, CA 90043

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, General Records Policies, dated 11/2021, the P&P indicated, The content will meet the requirements for compliance with the Center for Medicare and Medicaid Services (CMS) Department of Health and Licensing Certification to serve as the legal health record, meeting documentation and professional standards. The P&P indicated records will be filed in an accessible manner and easily retrieved within in the facility or in record storage. During a review of facility's Charge Nurse-RN/LVN Job Description, the Charge Nurse LVN/RN Job Description indicated to ensure documentation is complete and legible at all times and to report results of labs, x-ray, etc. to physician, documenting call, response, and new orders as appropriate.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure staff disinfected blood pressure cuffs before and after use during medication administration affecting two of four residents observed for medication administration (Residents 32 and 40.) The deficient practice of failing to disinfect shared medical equipment before and after use on different residents increased the risk that Residents 32 and 40 could have developed an infection (the invasion and growth of germs in the body) causing medical complications possibly leading to hospitalization. Findings: During an observation of medication administration with the Licensed Vocational Nurse (LVN 1) on 6/25/25 at 8:09 AM, LVN 1 was observed taking Resident 32 ' s blood pressure with an automatic blood pressure machine with a Velcro-style cuff without first disinfecting it. When complete, LVN 1 was observed placing the blood pressure machine and cuff back into its case, closing it with a zipper, and placing it back in the bottom drawer of the medication cart without first disinfecting it. During an observation on 6/25/25 at 8:24 AM, LVN 1 was observed using the same blood pressure machine and cuff to take Resident 40 ' s blood pressure without disinfecting the cuff. When complete, LVN 1 was observed placing the machine and blood pressure cuff back into its case again without first disinfecting it. During an interview on 6/25/25 at 8:30 AM with LVN 1, LVN 1 stated she failed to clean or disinfect the BP cuff before or after taking the blood pressure for Resident 32 and 40. LVN 1 stated she is required to clean the blood pressure cuff before and after each use and stated she has no excuse for not doing it. LVN 1 stated failing to disinfect shared medical equipment, such as the blood pressure cuff, increases the risk of spreading infections between residents which could lead to medical complications including hospitalization. A review of the facility ' s policy Cleaning and Disinfecting Vital Signs Machine, revised August 2017, indicated It is the policy of the facility to maintain clean resident equipment . After each use: Clean and disinfect all resident-contact surfaces . Wipe down the following areas thoroughly . blood pressure cuff and tubing .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure residents in rooms 101, 102, 103, 104, 105, 106, 107, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121,122, 123, 126, and 127 had at least 80 square feet ([sqft]- a unit of measure) of living space. This deficient practice had the potential to result in residents not being able to move around freely or store personal items. Staff may also have difficulty providing care due to a lack of space. Findings: During an observation on 6/24/2025 at 10:29 a.m., room [ROOM NUMBER] was noted to contain three beds. During a review of the Client Accommodation Analysis, dated 6/26/2025, the analysis indicated the facility had the following room measurements: Room # # of beds Floor square footage 101 3 215 102 3 215 103 3 215 104 3 215 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	105 3 215 106 3 215 107 3 215 108 2 160 109 3 215 110 3 215 111 3 215 112 3 215 114 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	3 215 115 3 215 116 3 215 117 2 147 118 3 215 119 3 215 120 3 215 121 3 215 122 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	3 215 123 3 215 124 2 213 126 3 215 127 3 216 During a review of the Room Variance Waiver request letter, dated 6/26/2025, the letter indicated the facility is requesting a waiver for the following rooms: 101, 102, 103, 104, 105, 106, 107, 109, 110, 111, 112, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 126, 127. The letter further stated the configuration of the rooms allows for the accessibility of wheelchairs, comfort/privacy of residents, and does not hinder care. During an interview on 6/27/2025 at 12:25 p.m. with the Assistant Administrator (AADM), the AADM stated the smaller rooms could potentially make it difficult for nursing staff to provide care.