STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555012	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, comfortable, and homelike environment for two of two sampled residents (Residents 8 and 1) reviewed under Environment task and one of one sampled resident (Resident 50) during a random observation by failing to: 1. Ensure Resident 8 and 1's window was well sealed after the installation of a temporary portable Air Conditioner (AC - a freestanding, self-contained cooling unit) unit. 2. Maintain the cleanliness of Resident 50's electric desk fan. These deficient practices had the potential to negatively affect the residents' quality of life. Findings: a. During a review of Resident 8's Face Sheet (FS), the FS indicated that the facility originally admitted the resident on 4/30/2024, and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), obstructive sleep apnea (a disorder where breathing repeatedly stops and starts during sleep when the throat muscles relax and cause the airway to collapse and block airflow), and convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). During a review of Resident 8's History and Physical (H&P), dated 12/26/2025, the H&P indicated that resident could make needs known, but cannot make medical decisions. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2026, the MDS indicated the resident makes self-understood and had the ability to understand others. The MDS indicated the resident was dependent on staff with eating, oral hygiene, toileting, shower/bathe self, lower body dressing, personal hygiene and mobility. b. During a review of Resident 1's FS, the FS indicated that the facility originally admitted the resident on 11/10/2025, and readmitted on [DATE], with diagnoses including pulmonary fibrosis (scarring in the tissue inside the lungs), emphysema (a progressive lung disease that causes shortness of breath), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's H&P, dated 4/10/2026, the H&P indicated that the resident had the capacity to understand and make decisions at this time. During a review of Resident 1's MDS, dated [DATE], the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired) and oxygen therapy was performed while Resident 1 was a resident of the facility. The MDS indicated the resident required staff supervision or touching assistance with mobility. During an interview on 5/4/2026 at 10 a.m. with Resident 1, inside Resident 1's room, Resident 1 (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that a portable AC was provided because they complained about the heat during hot weather in their room. Resident 1 stated that the room tends to become warm and they are also next to the laundry room. Resident 1 stated that their room also gets cold, so they have not turned on the portable AC. During a concurrent observation and interview on 5/4/2026 at 10:05 a.m. with Resident 8, inside Resident 8's room, observed portable AC with exhaust pointed outside the window. Resident 8 stated that he (Resident 8) does not remember when the portable AC was placed there but the room does get warm on hot days.ˆResident 8 stated the last few days it has been really cold especially at night, so they have not used the portable AC lately. During a concurrent observation and interview on 5/4/2026 at 3:20 p.m. with Licensed Vocational Nurse (LVN) 1, inside Resident 8 and 1's room, observed portable AC attached to the window with blue painter's tape. LVN 1 stated that the painter's tape is loose, and he (LVN 1) could feel the breeze coming in through the window. LVN 1 stated it should be well-sealed; there should be no gaps because it defeats the purpose of regulating the temperature in the room with the portable AC.ˆ During an interview on 5/7/2026 at 2:26 p.m. with the Infection Preventionist (IP), the IP stated that the portable AC is operated by the maintenance department. The IP stated the seal is also maintained by the maintenance department. The IP stated the seal needs to be properly secured to prevent outside air from entering as this may affect the resident's respiratory condition and must be protected. The IP stated the room temperature may also be affected by not having well sealed panel on the window. The IP stated the hot air keeps coming in and defeats the purpose of cooling the room. The IP stated the exhaust is pointing towards the parking lot and if the bad air quality gets inside the room, then there is a potential for the residents to develop respiratory infection such as pneumonia (lung infection), and this may cause coughing and shortness of breath. During an interview on 5/8/2026 at 11:18 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the purpose of the seal on the portable AC panel is to prevent the outside air from entering inside the residents' room. The ADON stated they do not know the air quality and temperature outside and this may cause potential harm to the residents such as change in the room temperature which can potentially cause respiratory infection. The ADON stated the fluctuation in air temperature make the residents' room uncomfortable and do not support a homelike environment for the residents. c. During a review of Resident 50's FS, the FS indicated the facility originally admitted the resident on 5/17/2021, and readmitted in the facility on 8/8/2025, with diagnoses including Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 50's H&P dated 8/10/2025, the H&P indicated that Resident 50 did not have the capacity to understand and make decisions. During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make her needs known. The MDS further indicated that Resident 50 required supervision or touching assistance with eating and total assistance from staff with all other activities (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 5/6/2026 at 7:37 a.m., inside Resident 50's room, observed Resident 50's electric desk fan with moderate amount of gray colored streaks on the front and back panel as well as the fan blades. During a concurrent observation and interview on 5/6/2026 at 7:45 a.m. inside Resident 50's room with Certified Nursing Assistant (CNA) 4, CNA 4 stated that she (CNA 4) did not notice that Resident 50's desk fan was dirty and had gray colored dusts in the front and back and was blowing facing the resident. CNA 4 stated that the gray streaks are dust. CNA 4 stated that the maintenance is responsible for cleaning the fan. CNA 4 stated that the staff is also responsible in reporting to the maintenance department if any resident care equipment needs to be cleaned. CNA 4 stated that Resident 50's and all other residents' environment should be clean and dust free. During a concurrent interview and record review on 5/7/2026 at 11:33 a.m., reviewed a photograph of Resident 50's desk fan with the ADON. The ADON stated that Resident 50's desk fan had a lot of gray colored dusts in the front and back panel. The ADON stated that the maintenance department was responsible in making sure the electric fans or any resident equipment is clean to provide a homelike environment to the residents. The ADON stated that the staff was responsible in notifying the maintenance department that Resident 50's desk fan had a lot of gray dusts. The ADON stated that Resident 50's desk fan should have been kept clean as the resident can inhale the air coming out from the fan with the dust particles and can be a source of infection, and it was also not providing a homelike environment for Resident 50. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed and approved on 1/2026, the P&P indicated that Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include a. clean, sanitary and orderly environment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for two of five sampled residents (Resident 23 and 7) reviewed during the Medication Administration task, by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 3 administered medication in the form prescribed by the physician and per facility policy and procedure (P&P) when LVN 3 crushed (pressing very hard so that the shape is destroyed and forms a soft powder) and administered Resident 23's crushed medications without a physician's order on 5/6/2026 during the 9 a.m. routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely). These failures had the potential to result in Resident 23 experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in a negative impact to Resident 23's health and well-being. 2. Failing to ensure Licensed Vocational Nurse (LVN) 2 notified the physician about Resident 7's request for a change in the medication administration medication timing for sennosides (senna - a stimulant laxative used to treat constipation). This deficient practice had the potential to place the resident at risk of further discomfort from constipation and delay in necessary care. Cross reference F759. Findings: a. During a review of Resident 23's Face Sheet (FS – admission Record), the FS indicated the facility originally admitted the resident on 2/9/2024 and most recently admitted the resident on 11/24/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure), unspecified dementia (a progressive state of decline in mental abilities), and major depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 23's History and Physical (H&P), dated 11/25/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. The H&P further indicated the resident had additional diagnoses of metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), moderate protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and dysphagia (difficulty swallowing). During a review of Resident 23's Minimum Data Set (MDS – a resident assessment tool), dated 2/17/2026, the MDS indicated the resident rarely / never was able to understand others and rarely / never was able to make himself understood. The MDS further indicated the resident was dependent on staff for eating, toileting, bathing, personal and oral hygiene, dressing, and mobility. During a review of Resident 23's Care Plan (CP) titled, The Resident has an alteration in neurological status related to metabolic encephalopathy, dementia, elevated ammonia (a chemical made by bacteria in the intestines) level, initiated 11/27/2025, the CP indicated interventions that included to adjust the diet to accommodate chewing, swallowing or eating issues and to give medications as ordered. During a review of Resident 23's Physician Order Summary, the Physician Order Summary indicated the following orders: 1. Amlodipine Besylate (medication to treat HTN) oral tablet five (5) milligrams (mg - a unit of measurement) give one (1) tablet by mouth 1 time a day for HTN, dated 11/24/2025. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Ascorbic acid (vitamin C - a dietary supplement) tablet 500 mg, give 1 tablet by mouth two times a day for supplement, dated 1/26/2025. 3. Memantine HCL (medication to treat symptoms of dementia) oral tablet 10 mg, give 1 tablet by mouth 1 time a day related to unspecified dementia for seven (7) days, dated 4/30/2026. 4. Multi-vitamin with minerals (a dietary supplement) oral tablet, give 1 tablet by mouth 1 time a day for supplement, dated 11/25/2025. 5. Oyster shell calcium / vitamin D (a dietary supplement to treat low levels of calcium) tablet 500 – 200 mg-unit, give 1 tablet by mouth two times a day for supplement, dated 11/24/2025. 6. Rifaximin (an antibiotic that reduces ammonia production) oral tablet 550 mg, give 1 tablet by mouth two times a day for hyperammonemia (high levels of ammonia in the blood), dated 3/18/2026. 7. Sertraline HCL (medication used to manage and treat major depressive disorder) oral tablet, give 25 mg by mouth one time a day for depression manifested by verbally expressing sadness, dated 3/7/2026. During a Medication Administration Observation on 5/6/2026 at 8:17 a.m., with LVN 3, LVN 3 stated she would prepare Resident 23's 9 a.m. medications at Station 1 Medication Cart 1. LVN 3 stated Resident 23 was on a pureed diet (texture-modified foods for those who can't handle solid food due to chewing or swallowing difficulties) and she (LVN 3) will crush the medications and administer them with apple sauce. Observed LVN 3 crushed the following medications: amlodipine tablet 5 mg, ascorbic acid tablet 500 mg, memantine HCL tablet 10 mg, multi-vitamin with minerals tablet, oyster shell calcium / vitamin D tablet 500 – 200 mg, rifaximin tablet 550 mg, and sertraline HCL tablet 25 mg. LVN 3 then entered Resident 23's room and administered the crushed medications with applesauce. During a follow-up interview and concurrent record review on 5/6/2025 at 12:54 p.m. with LVN 3, LVN 3 reviewed Resident 23's physician orders. LVN 3 stated she (LVN 3) crushed Resident 23's medications because there was an order to crush them and it would not be safe for the resident to swallow the medications whole. LVN 3 then reviewed Resident 23's physician's orders and noted there was no order indicating to crush medications. LVN 3 stated she should have checked for an order to crush the medications prior to administering them to Resident 23, but she did not. LVN 3 stated she assumed Resident 23 had an order to crush the medications. LVN 3 stated when Resident 23's medications were crushed and administered without an order, there was potential to crush and administer a medication that should not be crushed. During a concurrent interview and record review on 5/6/2026 at 1:47 p.m. with the Director of Nursing (DON), the DON reviewed the facility P&P regarding medication administration and crushing medications. The DON stated the facility process for administering crushed medications is that a physician's order is required prior to crushing and administering the medication. The DON stated if a resident has difficulty swallowing then the nurse should contact the physician for an order to crush the medications. The DON stated a physician's order is required to crush medication because a nurse is altering the medication when a tablet is crushed and all resident care requires an order. The DON stated not all medications can be crushed because altering the tablet may change a medications action on the body resulting in adverse effects. The DON stated when LVN 3 crushed and administered Resident 23's medication without a physician's order the facility P&P was not followed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resulting in medication errors with the potential for side effects in Resident 23. During a review of the facility P&P titled, Medication Administration – General Guidelines, last reviewed 1/2026, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedure - Preparation:. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines:. Long-acting or enteric coated dosage forms should generally not be crushed; an alternative should be considered. Procedure - Administration:. Medications are administered in accordance with written orders of the attending physician. During a review of the facility P&P titled, Crushing Medications, last reviewed 1/2026, the P&P indicated, Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders. The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify appropriate indications and procedures for crushing medications. In addition, the following guidelines shall be followed when crushing medications: . a. The MAR or other documentation must indicate why it was necessary to crush the medication. b. During a review of Resident 7's FS, the FS indicated that the facility originally admitted the resident on 6/19/2023 and readmitted on [DATE] with diagnoses including chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), end stage renal failure (ESRD- irreversible kidney failure), and pain in left shoulder. During a review of Resident 7's H&P, dated 8/31/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated that the resident required staff assistance with upper and lower body dressing, putting on/taking off footwear, personal hygiene, walk 50 feet (ft – a unit of measurement) with two turns and walk 150 ft. During a review of Resident 7's physician order, dated 3/24/2026, the physician order indicated sennosides tablet 8.6 milligrams (mg – a unit of measurement), give two (2) tablet by mouth two times a day every Monday, Wednesday, and Friday for bowel management, hold for loose stools. During an observation on 5/6/2026 at 8:35 a.m. with Licensed Vocational Nurse (LVN) 2, observed medication administration for Resident 7. LVN 2 prepared the medications including sennosides two tablets. During an observation on 5/6/2026 at 8:47 a.m. with LVN 2, at Resident 7's room, LVN 2 administered medications to Resident 7. LVN 2 stated the last tablets are senna. Resident 7 stated he cannot take senna because he has dialysis (a type of treatment that helps your body remove extra fluid and waste products from your blood when the kidneys are not able to) today. During an interview on 5/6/2026 at 8:53 a.m., LVN 2 stated he completed medication administration and will inform his supervisor regarding Resident 7's report of pain.ˆLVN 2 stated he does not know if he provided risks and benefits senna to Resident 7. LVN 2 stated he documented risks & benefits (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explained x3.ˆ Communicated to LVN 2 that him explaining risk and benefits was not observed. LVN 2 stated when he administered senna to Resident 7 and resident responded he has dialysis he considers that as a refusal because the resident did not want to take the medication at the scheduled time.ˆLVN 2 stated he can go to the resident and explain the risk and benefits of not taking senna. During a follow-up interview on 5/6/2026 at 8:59 a.m. with Resident 7, at Resident 7's room, Resident 7 stated that he did not refuse to take senna today. Resident 7 stated on dialysis days he does not take it before he leaves because he cannot go anywhere for four hours because he is on dialysis. Resident 7 stated he takes senna every day for constipation. Resident 7 stated the staff offers it to him when he returns from dialysis. During a concurrent interview and record review on 5/6/2026 at 2:11 p.m. with LVN 2, reviewed Resident 7's physician order, LVN 2 stated Resident 7's senna is scheduled twice a day at 9 a.m. and 5 p.m. LVN 2 stated Resident 7 expected return from dialysis around 3 p.m. LVN 2 stated for senna at least four hours apart from the next dose the if her offers it at 3 p.m. it would be too close on administration for the next scheduled time at 5 p.m. LVN 2 stated he should have notified Resident 7's physician regarding his request to change the timing of the senna not on dialysis days. LVN 2 stated he should have explained the risks and benefits of not taking senna and he did not document it accurately on the resident's record. During an interview on 5/8/2026 at 11:29 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the LVN should have clarified with Resident 7 what he meant by dialysis day and if refused should have asked the doctor the proper bowel management for Resident 7 if it is one in the morning or in the evening and communicated that Resident 7 has dialysis on those days and the doctor can prescribe the medication timing. The ADON stated the LVN should have given the details of the medication request, and which preferred timing. The ADON stated the purpose of clarification with Resident 7 is because the resident is alert and is his preference. The ADON stated resident's preference is part of their rights, treatment, and plan of care. The ADON stated they should honor the resident's preference and communicate with the resident's doctor. During a review of the facility's P&P titled, Administering Medications, last reviewed and approved on 1/2026, the P&P indicated that Medications are administered in a safe and timely manner, and as prescribed. 5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:. c. honoring resident choices and preferences, consistent with his or her care plan.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow the menu and did not meet nutritional needs for twelve (12) out of 12 Residents on pureed diet when Speech Therapist (SLP) 1 instructed the [NAME] (CK) to add liquid thickener to the blended food not measured according to specified recipe on adding substitutes. This deficient practice had the potential to cause difficulty in eating, chewing, and swallowing to the residents, cause resident dissatisfaction, and increase food and nutrient intake resulting to unintended (not done on purpose) weight loss. Cross-reference F805. Findings: During a review of Resident 12's admission Record (AR), the AR indicated the facility initially admitted the resident on 11/3/2023, and was readmitted on [DATE], with diagnoses including malnutrition (the body not getting the right balance of nutrients it needs to work correctly), muscle weakness, dementia (a progressive state of decline in mental abilities), and depression (a serious long-lasting mental health condition where a constant state of loneliness and loss of interest takes over). During a review of Resident 12's History and Physical (H&P), dated 6/23/2025, the H&P indicated Resident 12 does not have the capacity to understand and make decisions. During a review of the facility's Diet Order Tally Report - All Textures list, the diet order indicated Resident 12 is on a pureed diet. During an observation on 5/4/2026 at 11:21 a.m. in trayline (an area where foods were assembled) with SLP 1, SLP 1 observed performing the fork drip test (test used to check the correct thickness and cohesiveness) to check the consistency of the pureed diet. SLP 1 observed instructing the CK to add more liquid thickener to the blended food when the consistency was not to her (SLP 1) liking. The CK observed adding a stabilizer of liquid thickener using a pump to add to the blended food. The SLP observed telling the cook that it was at the correct consistency of the pureed diet and was okay to serve. The SLP left the kitchen as the kitchen staff started preparing for the trayline. During the end of tray line observation, the pureed diet looked runny and did not hold its shape. During a review of the facility's menu titled, Good For Your Health Menus, the menu indicated on 5/04/2026 lunch menu includes: Tarragon chicken, oven roasted potatoes, green beans with red bell peppers, broccoli salad, and tropical fruit mold. During a review of the facility's recipe for twelve (12) servings pureed food for the following: - Recipe: Pureed (IDDSI Level #4) Meats, include: 12 to 24 ounce (1 1/2 to 3 cups), - Recipe: Pureed (IDDSI Level #4) Vegetables, include: 2 to 6 ounce (1/4 cup to 3/4 cup), - Recipe: Pureed (IDDSI Level #4) Starch (Rice, Pasta, Polenta, Potatoes, etc.) include: 12 to 24 ounce (1 1/2 to 3 cups), If needed: Stabilizer 6 to 12 tbsp (3/8 - 3/4 cup) instant potato, non-fat dry milk, breadcrumbs, toast, instant cream of rice or farina, or commercial instant food thickener. During dining observation on 5/4/2026 at 12:50 p.m., Resident 12's had a diet consisting of runny brown, green and light, yellow-colored food in a plate. Resident 12 was observed feeding self with a spoonful of chocolate pudding, half a spoon of the brown-colored food in the plate and a sip of thickened red juice. Resident 12 observed indicating through gesture that she no longer wished to continue eating. During a concurrent interview and record review on 5/7/2026 at 12:33 p.m. with the Registered Dietician (RD), the RD stated the role of the SLP is to make sure the consistency of International Dysphagia Diet Standardization Initiative (IDDSI, a globally standardized framework for texture-modified foods and thickened liquids) Level 4: Pureed is being followed. The RD stated that on 5/4/2026 the pureed diet that was served at lunch did not reach the adequate consistency of the ideal puree blend. The RD further stated that the pureed diet that was served on 5/4/2026 looked different and did not hold its shape. The RD stated that it is important for the pureed diet to keep its shape for palatability and is a dignity issue. During a concurrent interview and record review on 5/7/2026 at 1:11 p.m. with the Dietary Supervisor (DS), the DS stated pureed diet should be smooth, free of lumps, not runny or hard, and should hold its shape. The DS stated that puree consistency should be checked every 10 to 15 minutes to adjust if thickener needed to be added or not. The DS stated depending on (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the kind of food, potato powder is being used to get the ideal puree consistency. The DS stated that on 5/4/2026, liquid thickener was added to the blended food that most likely showed a watery and flat consistency on the pureed diet. The DS stated that the appearance of the pureed diet served may not be pleasant to residents and could possibly not have the appetite to eat. During an interview on 5/7/2026 at 3:10 p.m. with SLP 2, SLP 2 stated that she had a training for IDDSI diet and had in-services regarding changes of diet. SLP 2 stated she goes to kitchen the kitchen to check the consistency of pureed diet. SLP 2 stated that if the pureed food does not meet its consistency, she provided recommendation and the cook adds the thickener. SLP 2 stated that she is uncertain of the appropriate amount of thickener required, SLP2 further added that she is provided with spreadsheet and cook has the recipe, who is responsible for adding the thickener, while her role is to only verify the consistency. During an interview on 5/8/2026 at 2:15 p.m. with Director of Nursing (DON), the DON stated that pureed diet at lunch on 5/4/2026 was runny and did not hold its shape. The DON stated that the pureed served did not look appealing to the residents. The DON stated that residents could possibly lose their appetite and not have enough food intake which can lead to weight loss. During a review of the facility's policy and procedure (P&P) titled, IDDSI LEVEL #4: REGULAR PUREED DIET, dated 2025, the P&P indicated a description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing or swallowing. The texture of the prepared pureed food items included on this diet should be smooth and free of lumps, hold their shape, while not too firm or sticky, and should not weep.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prepare foods in a form designed to meet individual needs when residents on pureed diet (diet consisted of food that are blended, whipped, or mashed into a smooth, thick consistency similar to pudding) received meals that were runny and did not hold its form for twelve (12) out of 12 Residents on pureed diet. This deficient practice had the potential to cause difficulty in eating, chewing, and swallowing to the residents, cause resident dissatisfaction, and increase food and nutrient intake resulting to unintended (not done on purpose) weight loss. Cross-reference F803.Findings: During a review of Resident 12's admission Record (AR), the AR indicated the facility initially admitted the resident on 11/3/2023, and was readmitted on [DATE], with diagnoses including malnutrition (the body not getting the right balance of nutrients it needs to work correctly), muscle weakness, dementia (a progressive state of decline in mental abilities), and depression (a serious long-lasting mental health condition where a constant state of loneliness and loss of interest takes over). During a review of Resident 12's History and Physical (H&P), dated 6/23/2025, the H&P indicated Resident 12 does not have the capacity to understand and make decisions. During a review of the facility's Diet Order Tally Report - All Textures list, the diet order indicated Resident 12 is on a pureed diet. During an observation on 5/4/2026 at 11:21 a.m. in trayline (an area where foods were assembled) with Speech Therapist 1 (SLP 1), SLP 1 observed performing the fork tilt test to check the consistency of the pureed diet. SLP 1 observed instructing the [NAME] (CK) to add more liquid thickener to the blended food when the consistency was not to her liking. The CK observed adding a stabilizer of liquid thickener using a pump to add to the blended food. The SLP observed telling the cook that it was at the correct consistency of the pureed diet and was okay to serve. The SLP left the kitchen as the kitchen staff started preparing for the trayline. During the end of tray line observation, the pureed diet looked runny and did not hold its shape. During a review of the facility's menu titled, Good For Your Health Menus, the menu indicated on 5/4/2026 lunch menu includes: Tarragon chicken, oven roasted potatoes, green beans with red bell peppers, broccoli salad, and tropical fruit mold. During a review of facility's recipe for twelve (12) servings pureed food for the following: - Recipe: Pureed (International Dysphagia Diet Standardization Initiative [IDDSI - a globally standardized framework for texture-modified foods and thickened liquids]) Level #4) Meats, include: 12 to 24 ounce (1 1/2 to 3 cups), - Recipe: Pureed (IDDSI Level #4) Vegetables, include: 2 to 6 ounce (1/4 cup to 3/4 cup), - Recipe: Pureed (IDDSI Level #4) Starch (Rice, Pasta, Polenta, Potatoes, etc.) include: 12 to 24 ounce (1 1/2 to 3 cups), If needed: Stabilizer 6 to 12 tbsp (3/8 - 3/4 cup) instant potato, non-fat dry milk, breadcrumbs, toast, instant cream of rice or farina, or commercial instant food thickener. During a dining observation on 5/4/2026 at 12:50 p.m., Resident 12's meal tray had a diet consisting of runny brown, green and light, yellow-colored food in a plate. Resident 12 was observed feeding self with a spoonful of chocolate pudding, half a spoon of the brown-colored food in the plate and a sip of thickened red juice. Resident 12 observed indicating through gesture that she no longer wished to continue eating. During an interview on 5/7/2026 at 12:33 p.m. with Registered Dietician (RD), the RD stated the role of SLP is to make sure the consistency of IDDSI Level 4: Pureed is being followed. The RD stated that on 5/4/2026 the pureed diet that was served at lunch did not reach the adequate consistency of the ideal puree blend. The RD further stated that the pureed diet that was served on 5/4/2026 looked different and did not hold its shape. The RD stated that it is important for the pureed diet to keep its shape for palatability and is a dignity issue. During a concurrent interview and record review on 5/7/2026 at 1:11 p.m. with the Dietary Supervisor (DS), the DS stated pureed diet should be smooth, free of lumps, not runny or hard, and should hold its shape. The DS stated that puree consistency should be checked every 10 to 15 minutes to adjust if thickener needed to be added or not. The DS stated depending on the kind of food, (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	potato powder is being used to get the ideal puree consistency. The DS stated that on 5/4/2026, liquid thickener was added to the blended food that most likely showed a watery and flat consistency on the pureed diet. The DS stated that the appearance of the pureed diet served may not be pleasant to residents and could possibly not have the appetite to eat. During an interview on 5/7/2026 at 3:10 p.m. with SLP 2, SLP 2 stated that she had a training for IDDSI diet and had in-services regarding changes of diet. SLP 2 stated she goes to the kitchen to check the consistency of pureed diet. SLP 2 stated that if the pureed food does not met its consistency, she provided recommendation and the cook adds the thickener. SLP 2 stated that she is uncertain of the appropriate amount of thickener required, SLP2 further added that she is provided with spreadsheet and cook has the recipe, who is responsible for adding the thickener, while her role is to only verify the consistency. During an interview on 5/8/2026 at 2:15 p.m. with the Director of Nursing (DON), the DON stated that pureed diet at lunch on 5/4/2026 was runny and did not hold its shape. The DON stated that the pureed served did not look appealing to the residents. The DON stated that residents could possibly lose their appetite and not have enough food intake which can lead to weight loss. During a review of the facility's Policy and Procedure (P&P) titled, IDDSI LEVEL #4: REGULAR PUREED DIET, dated 2025, the P&P indicated a description: The pureed diet is a regular diet that has been designed for residents who have difficulty chewing or swallowing. The texture of the prepared pureed food items included on this diet should be smooth and free of lumps, hold their shape, while not too firm or sticky, and should not weep.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a complete and accurate medical records in accordance with accepted professional standards for one of five sampled residents (Resident 7) reviewed for medication administration task and two of three sampled residents (Resident 40 and 64) by failing to: 1. Ensure that Licensed Vocational Nurse (LVN) 2 accurately documented Resident 7's request for a change in the medication administration timing and instead recorded the request as a refusal. This deficient practice had the potential to result in inaccurate information entered in Resident 7's medical record. 2. Accurately document Resident 64`s fluid intake in the Medication Administration Record (MAR, a list of scheduled medications and other instructions ordered by the medical doctor) on May 1,2026. 3. Accurately document the time Vancomycin (medication to treat infection) ordered for 1700 and was documented given at 2109. These deficient practices have the potential to result in incomplete, inaccurate, or delayed records that could lead to miscommunication between healthcare providers and resident harm. Findings: a. During a review of Resident 7's Face Sheet (FS), the FS indicated that the facility originally admitted the resident on 6/19/2023, and readmitted on [DATE], with diagnoses including chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), end stage renal failure (ESRD- irreversible kidney failure), and pain in left shoulder. During a review of Resident 7's History and Physical (H&P), dated 8/31/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 3/26/2026, the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated that the resident required staff assistance with upper and lower body dressing, putting on/taking off footwear, personal hygiene, walk 50 feet (ft – a unit of measurement) with two turns and walk 150 ft. During a review of Resident 7's physician order, dated 3/24/2026, the physician order indicated sennosides (medication to treat constipation [a problem with passing stool]) tablet 8.6 milligrams (mg – a unit of measurement), give two (2) tablet by mouth two times a day every Monday, Wednesday, and Friday for bowel management, hold for loose stools. During an observation on 5/6/2026 at 8:35 a.m. with Licensed Vocational Nurse (LVN) 2, observed medication administration for Resident 7. LVN 2 prepared the medications including sennosides two tablets. During an observation on 5/6/2026 at 8:47 a.m. with LVN 2, inside Resident 7's room, LVN 2 administered medications to Resident 7. LVN 2 stated the last tablets are senna. Resident 7 stated he (Resident 7) cannot take senna because he (Resident 7) has dialysis today. During an interview on 5/6/2026 at 8:53 a.m., LVN 2 stated he (LVN 2) completed medication administration and will inform his supervisor regarding Resident 7's report of pain.ˆLVN 2 stated he (LVN 2) does not know if he (LVN 2) provided the risks and benefits of senna to Resident 7. LVN 2 stated he (LVN 2) documented that he (LVN 2) explained the risks & benefits to the resident three times.ˆ (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Communicated to LVN 2 that the explanation of risks and benefits to Resident 7 was not observed. LVN 2 stated when he (LVN 2) administered senna to Resident 7 and the resident responded that he (Resident 7) has dialysis he (LVN 2) considers that as a refusal because the resident did not want to take the medication at the scheduled time.ˆLVN 2 stated he (LVN 2) can go to the resident and explain the risks and benefits of not taking senna. During a follow-up interview on 5/6/2026 at 8:59 a.m. with Resident 7, inside Resident 7's room, Resident 7 stated that he (Resident 7) did not refuse to take senna today. Resident 7 stated on dialysis days he (Resident 7) does not to take it before he (Resident 7) leaves because he (Resident 7) cannot go anywhere for four hours because he (Resident 7) is on dialysis. Resident 7 stated he (Resident 7) takes senna every day for constipation. Resident 7 stated that the staff offers this medication to him when he (Resident 7) returns from dialysis. During a concurrent interview and record review on 5/6/2026 at 2:11 p.m. with LVN 2, Resident 7's physician orders were reviewed. LVN 2 stated Resident 7's senna is scheduled twice a day at 9 a.m. and 5 p.m. LVN 2 stated Resident 7`s expected return time from dialysis is around 3 p.m. LVN 2 stated senna doses are required to be administered at least four hours apart from each other and if he offers the medication at 3:00 p.m., it would be too close on administration for the next scheduled time at 5 p.m. LVN 2 stated he (LVN 2) should have notified Resident 7's physician regarding his request to change the timing of the senna not on dialysis days. LVN 2 stated he (LVN 2) should have explained the risks and benefits of not taking senna and he (LVN 2) did not document it accurately on the resident's record. LVN 2 stated the purpose of accurately documenting is to show the trail and history of the resident's care and treatment. LVN 2 stated the resident's quality of care could be affected. LVN 2 stated when a resident`s documentation reflects a refusal rather than a request; it may be misconstrued as noncompliance instead of a request to modify the medication regimen.ˆ During an interview on 5/8/2026 at 11:29 a.m. with the Assistant Director of Nursing (ADON), the ADON stated LVN should have clarified with Resident 7 what he meant by dialysis day and if refused should have asked the doctor the proper bowel management for Resident 7 if it is one in the morning or in the evening and communicated that Resident 7 has dialysis on those days and the doctor can prescribe the medication timing. The ADON stated that LVN should have given the details of the medication request, and which preferred timing. The ADON stated the purpose of clarification with Resident 7 is because the resident is alert and able to express his preference. The ADON stated resident's preference is part of their rights, treatment, and plan of care. The ADON stated they should honor the resident's preference and communicate with the resident's doctor. The ADON stated LVN 2 documenting the refusal and not following up with the resident about what he (Resident 7) meant by him (Resident 7) having dialysis today does not show the whole picture. The ADON stated that when the resident's preference is not honored regarding the time he (Resident 7) wants to take his senna, the charge nurses in charge of Resident 7 would think that the resident is noncompliant and refuses medications. The ADON stated it is not accurate and they will correct that. During a review of the facility's P&P titled, Charting and Documentation, last reviewed and approved on 1/2026, the P&P indicated that All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 64's FS, the FS indicated the facility admitted the resident on 1/15/2026, and readmitted on [DATE], with diagnoses including muscle weakness, congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and ESRD. During a review of Resident 64's H&P, dated 4/26/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 64's MDS dated [DATE], the MDS indicated the resident did not have the capacity to make self-understood and understand others. The MDS further indicated that Resident 64 required substantial or maximal assistance for personal hygiene, dressing, and repositioning, and was dependent on staff for bathing and all other activities of daily living (ADLs, routine task/activity such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 64's Care Plan (CP) titled, The resident has actual/potential nutritional problem and dehydration risk related to (r/t) confusion r/t dementia initiated on 4/30/2026, the CP indicated an intervention that included Fluid Restriction (a medically prescribed limit on the total amount of liquids you can consume in a 24-hour period): 800 ml/24 hrs. Dietary: Breakfast – 240 ml Lunch – 120ml Dinner 240ml: Day shift – 100 ml Evening shift – 50 ml Night shift – 50 ml. Resident 64`s CP titled, The resident needs hemodialysis r/t renal failure/ESRD initiated on 1/17/2026 also indicated an intervention that included to monitor intake and output. During a concurrent interview and record review on 5/7/2026 at 8:36 a.m. with Registered Nurse 1 (RN1), RN1 stated that fluid restriction of 800 ml/24 hour was ordered for Resident 64. RN 1 stated that Licensed Vocational Nurse (LVN) is responsible for monitoring and documentation of residents` fluid restriction. RN 1 stated that on 5/1/2026, fluid restriction documentation for Resident 64 showed 360 ml for day, 120 ml for evening and 800 ml for night which totals the amount of 1,280 ml over a 24-hr period. RN 1 stated 800 ml that was documented by the Licensed Vocational Nurse 4 (LVN 4) totaled more than the fluid restriction ordered for the resident. RN 1 stated that it is important to follow doctor's orders. RN stated that Resident 64 is on dialysis and giving fluids more than what was ordered could cause urinary retention (the inability to completely empty the bladder), swelling and shortness of breath. During an interview and record review on 5/7/2026 at 10:39 a.m. with the ADON, the ADON stated that Resident 74`s fluid restriction order was not properly documented and could possibly be a charting error. The ADON stated that fluid restriction order must be properly communicated and documented throughout the health care team. RN stated that is important to monitor and follow doctor's orders on fluid restriction to avoid residents from having complications like fluids overload. During a telephone interview on 5/8/2026 at 4:13 p.m. with LVN 4, LVN 4 stated that Resident 64 has an order for fluid restriction of 800 ml/24-hour period. LVN 4 stated that he (LVN 4) erroneously charted 800 ml during night shift on 5/01/2026 and meant to document only 50 ml for his shift. LVN 4 stated that it is important to have proper documentation to avoid confusion amongst health care professionals. LVN 4 further stated that giving more that the fluid restriction can worsen resident's health problems which can lead to heart failure. During a review of the facility's P&P titled, Charting and Documentation, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1.Documentation in the medical record may be electronic, manual, or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications Administered; (.) 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. c. During a review of Resident 40's FS, the FS indicated the facility originally admitted the resident on 9/28/2022 and readmitted on [DATE], with diagnoses including hemiplegia (total paralysis or the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis on one side of the body affecting the arm, leg and sometimes the face), history of falling, and hypertension (high blood pressure). During a review of Resident 40's H&P, dated 4/06/2026, the H&P indicated that Resident 40 had the capacity to understand and make decisions. During a review of Resident 40's MDS, dated [DATE], the MDS indicated that the resident had a moderate cognitive impairment, able to make self-understood and understand others. The MDS further indicated that Resident 40 required touching to moderate assistance for personal hygiene, dressing, repositioning and dependent on staff with bathing and all other ADLs. During a review of Resident 40's Care Plan (CP) titled, The Resident had a ruptured intergleuteal (folds between buttocks) boil infection and on intravenous antibiotic (IV ATB) initiated on 4/22/2026 , the CP further indicated an intervention that included to administer antibiotic as per physician order. During a concurrent interview and record review on 5/07/2026 at 8:36 a.m. with RN 1, RN 1 stated that Resident 40 had an order for Vancomycin IV to be given at 5:00 p.m. for 14 days. RN 1 stated that on 5/3/2026, Vancomycin IV scheduled for 5:00 p.m. was given at 9:09 p.m. per MAR documentation. RN 1 stated that per facility policy medications are administered one (1) hour before or one (1) hour after their prescribed time, unless otherwise specified. RN stated that there was no documentation identifying the reason for the delay in administration of Vancomycin. RN 1 stated that there was no documentation whether Resident 40 had loss of IV access. RN 1 stated that Vancomycin is important to be given on time due to its trough level (a blood test that measures the lowest amount of antibiotic vancomycin in your body). RN 1 stated that if Vanco trough levels are too high, it can cause toxicity, and re-dosing is required to be done by the pharmacy depending on the levels. RN 1 stated that if there was a delay of administration, resident can possibly have false reading on levels and could affect kidney function. During a telephone interview on 5/08/2026 at 10:18 a.m. with RN 4, RN 4 stated that Vancomycin IV was scheduled for 5:00 p.m. and further stated that she (RN 4) gave the medication as ordered. When (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RN 4 was questioned about the documented time given at 9:09 p.m., RN 4 stated that she (RN 4) gave the medication at around 5:00 p.m. that day and had made an error documenting that it was given at 9:09 p.m. RN 4 stated that it is important to give the medication on time especially Vancomycin due to its peak and trough. RN 4 stated that if not given timely, it can affect the Vancomycin levels. RN 4 stated that Vancomycin can cause toxicity which can affect kidney function. During a concurrent interview and record review on 5/7/2026 at 10:39 a.m. with the ADON, the ADON stated that Vancomycin was documented past scheduled time. The ADON stated that medication administration must be given one hour before or one hour after the scheduled time. The ADON stated that Vancomycin should be given on time to get the effectiveness of the medication and target the bacteria especially with sensitivity involved as Vancomycin is based on timing with the peak and trough. The ADON stated that if Vancomycin is not given appropriately, there is high risk for re-infection with negative effect to kidney function. During a review of the facility's P&P titled, Charting and Documentation, the P&P indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1.Documentation in the medical record may be electronic, manual, or a combination. 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications Administered; (.) 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of facility's P&P titled, Administering Medications, the P&P indicated that: 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). During a review of Vancomycin manufacturer's guide titled, Vancomycin Hydrochloride – vancomycin hydrochloride injection, solution [NAME] Healthcare Corporation, under Antibacterial Resistance indicated that When Vancomycin injection is prescribed to treat a bacterial infection, patient should be told that although it is common to feel better in the course of therapy, the medication should be taken exactly as directed. Skipping doses or not completing the full course of therapy may (1) decrease the effectiveness of the immediate treatment and (2) increase the likelihood that bacteria will develop resistance and will not be treatable by Vancomycin injection or other antibacterial drugs in the future.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the electrical and resident care equipment in safe operating condition by failing to ensure that the Heating, Ventilation, and Air Conditioning (HVAC - are systems used to manage indoor climate and air quality) unit was in a safe and proper working condition starting on 9/10/2025 for three of three sampled residents (Residents 8, 1, and 7), in (4) of 4 residents rooms (rooms 36, 37, 38, and 39), and 4 of 4 other facility rooms including the rehabilitation therapy room, the Director of Nursing (DON)'s office, activity staff office room, and laundry room. These deficient practices had the potential to result in residents being exposed to dramatic changes in room temperature, poor ventilation and air quality which can lead to worsened respiratory symptoms and increase respiratory infection risk. Findings: a. During a review of Resident 8's Face Sheet (FS), the FS indicated that the facility originally admitted the resident on 4/30/2024 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), obstructive sleep apnea (a disorder where breathing repeatedly stops and starts during sleep when the throat muscles relax and cause the airway to collapse and block airflow), and convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). During a review of Resident 8's History and Physical (H&P), dated 12/26/2025, the H&P indicated that resident can make needs known, but cannot make medical decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 2/6/2026, the MDS indicated the resident makes self understood and has the ability to understand others. The MDS indicated the resident is dependent on staff with eating, oral hygiene, toileting, shower/bathe self, lower body dressing, personal hygiene and mobility. b. During a review of Resident 1's FS, the FS indicated that the facility originally admitted the resident on 11/10/2025 and readmitted on [DATE] with diagnoses including pulmonary fibrosis (scarring in the tissue inside the lungs), emphysema (a progressive lung disease that causes shortness of breath), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 1's H&P, dated 4/10/2026, the H&P indicated that the resident has the capacity to understand and make decisions at this time. During a review of Resident 1's MDS, dated [DATE], the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired) and oxygen therapy was performed while Resident 1 was a resident of the facility. The MDS indicated the resident required staff supervision or touching assistance with mobility. c. During a review of Resident 7's FS, the FS indicated that the facility originally admitted the resident on 6/19/2023 and readmitted on [DATE] with diagnoses including chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should), end stage renal failure (ESRD - irreversible kidney failure), and pain in left shoulder. During a review of Resident 7's H&P, dated 8/31/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated that the resident required staff assistance with upper and lower body dressing, putting on/taking off footwear, personal hygiene, walk 50 feet (ft - a unit of measurement) with two turns and walk 150 ft. During a concurrent observation and interview on 5/4/2026 at 9:47 a.m. with Resident 7, at Resident 7's room, observed a portable AC with vent taped to the window. Resident 7 stated the staff operates the portable AC. Resident 7 stated he does not remember when it was placed there. During an interview on 5/4/2026 at 10 a.m. with Resident 1, at Resident 1's room, Resident 1 stated they had the portable AC because they had complained about the heat during the hot weather their room would be warm and they are also next to the laundry room. Resident 1 stated that their room also gets cold (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	so they have not turned on the portable AC. During a concurrent observation and interview on 5/4/2026 at 10:05 a.m. with Resident 8, at Resident 8's room, observed a portable AC with exhaust pointed outside the window. Resident 8 stated he does not remember when the portable AC was placed there but the room does get warm on hot days.ˆResident 8 stated the last few days it has been really cold especially at night, so they have not used the portable AC lately. During a concurrent observation and interview on 5/5/2026 from 3:32 p.m. to 3:41 p.m. with the Assistant Director of Nursing (ADON), toured the facility: - inside the rehabilitation therapy room, the ADON stated there were two portable ACs sealed with one-sided adhesive foam. - inside the DON's office, the ADON stated one portable AC vent sealed with grey tape and adhesive foam. - inside room [ROOM NUMBER], the ADON stated one portable AC sealed with blue tape. - inside room [ROOM NUMBER], the ADON stated one portable AC sealed with blue tape. - inside room [ROOM NUMBER], the ADON stated one portable AC vent sealed with blue tape as well.ˆ - inside the laundry room with the ADON and the Laundry Manager (LM), the LM stated the portable AC has been here for about a month. - inside the activity staff office room, the ADON stated one portable AC sealed with blue tape. ˆDuring an interview on 5/6/2026 at 10:43 a.m. with the Maintenance Supervisor (MS), the MS stated nine (9) total portable AC in rooms with two portable AC in the rehabilitation therapy room and one portable AC in: the DON's office, activity staff office, laundry room, and in resident rooms 36, 37, 28, and 39. The MS stated all portable ACs were placed on 9/10/2025. The MS stated their HVAC system is functional, but that one HVAC unit was not working since 9/10/2025.ˆThe MS stated they are waiting for the ordered part which was ordered on 9/10/2025 and was received just last week due to being backtracked from the supplied. The MS stated they have 23 HVAC units servicing the facility and just one HVAC unit was not functioning. The MS stated the portable ACs were installed by their department, Maintenance department, they use the blue tape on the side using the panel from the manufacturer. The MS stated rooms 36, 37, 38, 39, laundry room, and rehabilitation therapy room is exhausting on the outside while the DON's office and the activity staff office portable ACs are exhausting to the patio. During an interview on 5/8/2026 at 11:18 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the purpose of the seal on the portable AC panel is to prevent the outside air from going inside the residents' room. The ADON stated they do not know the air quality and temperature outside and may cause potential harm to the residents such as change in the room temperature which can potentially cause respiratory infection. The ADON stated the residents' room would not be comfortable for the change in air temperature and would not be homelike to the residents. The ADON stated HVAC stands for heating, ventilation, air conditioning should have followed up more and has been following up end of day to ensure that residents are receiving homelike and comfortable environment and not temporary one. During a review of a facility-provided document invoice, dated 9/10, 2025, the invoice indicated that the HVAC Unit 38 - motherboard malfunctioning and not responding. Order for new motherboard placed and waiting on delivery for replacement of part. During a review of the facility's policy and procedure (P&P) titled, Maintenance Service, last reviewed and approved on 1/2026, the P&P indicated that Maintenance service shall be provided to all areas of the building, grounds, and equipment . 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to perform a medication self-administration assessment for one of three sampled residents (Resident 15) reviewed under the Accidents care area when Resident 15 kept oxymetazoline HCl nasal spray (a medication to treat congestion in the nasal passage) at the bed side for self-administration. This failure had the potential to result in violating Resident 15's right to self-administer medications and had the potential for the resident to experience adverse effects (an undesired effect of a drug or other type of treatment) from the self-administered medication. Cross-reference F689. Findings: During a review of Resident 15's Face Sheet (FS), the FS indicated the facility admitted the resident on 1/22/2026 and most recently admitted the resident on 2/20/2026 with diagnoses that included heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily functioning), and hypertension (high blood pressure). During a review of Resident 15's History and Physical (H&P), dated 2/21/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS - resident assessment tool), dated 2/25/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required supervision for eating, partial / moderate assistance for oral hygiene, and was dependent on staff for toileting and bathing. During a review of Resident 15's Admission/readmission Initial Assessment for Self-Administration of Medications (AASAM), dated 2/21/2026, the AASAM indicated the resident did not want to self-administer medications and no further assessment was completed. During a concurrent observation and interview on 5/4/2026 at 9:55 a.m., with Resident 15 in resident's shared room, observed a bottle of oxymetazoline HCl nasal spray sitting on the resident's bedside rolling table. Resident 15 stated he had allergies and used oxymetazoline HCl nasal spray whenever he needed it. During an observation on 5/4/2026 at 3:29 p.m., observed the oxymetazoline HCl nasal spray remained on Resident 15's bedside rolling table and was visible from the hallway. Observed Resident 15 was not in the shared room and no staff were present. During a concurrent observation and interview on 5/4/2026 at 3:32 p.m., with Resident 15 and Certified Nursing Assistant (CNA) 2, observed Resident 15 walked down the hallway carrying a shopping bag and entered his shared room where the oxymetazoline HCl nasal spray remained on the bedside rolling table, Resident 15 stated he had just returned. Observed CNA 2 then entered Resident 15's room and stated she did not notice the nasal spray when she was in the room before and she did not know why the resident needed the nasal spray. Resident 15 stated he had been using the nasal spray for about a month in the evenings for a stuffy nose. Observed CNA 2 exited the Resident 15's room and the nasal spray remained at bedside. Resident 15 stated the nasal spray had always been on the bedside rolling table and nobody had ever said anything about it. During a concurrent interview and record review on 5/4/2026 at 3:43 p.m. with Licensed Vocational Nurse (LVN) 5, Resident 15's physician orders for 5/2026 were reviewed. LVN 5 stated he had just started his shift at 3 p.m. LVN 5 stated that the facility process for medication self-administration was there must be an order for self-administration of medication because the physician has to authorize that the resident is able to self-administer. LVN 5 stated Resident 15 did not have a physician's order for oxymetazoline HCl nasal spray or an order that the resident may self-administer the medication. LVN 5 stated without an order, Resident 15 should not be self-administering oxymetazoline HCl nasal spray or storing the medication at bedside. During a follow-up concurrent observation and interview on 5/4/2026 at 4 p.m. with LVN 5, LVN 5 stated residents have the right to self-administer medication, and the facility protocol should be followed. LVN 5 stated all staff are responsible for checking the residents' environment for safety when they make rounds. LVN 5 stated when Resident 15 stored the nasal spray in view on the bedside table for self-administration, staff should have identified and removed the medication, notified the physician, (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and performed a self-administration of medication assessment, but they did not. LVN 5 stated it was important for the physician to be notified to ensure that the medication was not contraindicated, to obtain an order for administration, and ensure the medication was documented when administered. LVN 5 stated medications should never be left at bedside, even if a resident is safe for self-administration, because another confused resident may take the medication resulting in adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have). Observed LVN 5 entered Resident 15's room and removed the nasal spray. Observed Resident 15 stated to LVN 5 that he (Resident 15) had been using the nasal spray every night for about a month. During an interview on 5/5/2026 at 1:42 p.m. with LVN 3, LVN 3 stated she cared for Resident 15 on 5/4/2026 during the day shift. LVN 3 stated she (LVN 3) must have missed seeing the nasal spray on the resident's bedside rolling table. LVN 3 stated she should have caught the nasal spray stored on the table during rounds but did not. During a concurrent interview and record review on 5/8/2026 at 9:09 a.m., with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding self-administration of medications and resident safety and supervision was reviewed. The DON stated she was made aware that Resident 15 stored nasal spray at bedside for self-administration. The DON stated the facility has a process for when a resident expresses desire to self-administer medications that includes conducting a self-administration of medication assessment. The DON stated it was the responsibility of all the staff to make sure medications are not stored at bedside for self-administration and the medication should have been identified and was not. The DON stated nasal spray medication should not have been left at bedside because the resident may not be safe to self-administer and other residents could get the medication and drink it causing harm. During a review of the facility P&P titled, Self-Administration of Medications, last reviewed on 1/2026, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re?assessed periodically based on changes in the resident's medical and/or decision-making status. 4. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. 5. Residents who are identified as being able to self-administer medications are asked whether they wish to do so. 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility P&P titled, Resident Rights, last reviewed on 1/2026, the P&P indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . hh. self-administer medication, if the interdisciplinary care planning team determines it is safe.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview and record review, the facility failed to ensure resident's medical records were updated to show documented evidence that formulation of an advanced directive (a legal document indicating resident preference on end-of-life treatment decisions) was discussed for one (1) of 1 sampled resident (Resident 21) reviewed under the advance directive care area. This deficient practice violated the resident`s rights and/or the resident`s representative`s right to be fully informed of the option to formulate an AD and had the potential to delay emergency treatment or the potential to force emergency, life-sustaining procedures against the resident's personal preferences. Findings: During a review of Resident 21's admission Record, the admission Record indicated the facility admitted the resident on 12/26/2025, with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dementia (a progressive state of decline in mental abilities), and anxiety disorder (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress). During a review of Resident 21's History and Physical (H&P) dated 12/27/2025, the H&P indicated Resident 21 did not have the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 2/1/2026, the MDS indicated Resident 21 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and sometimes able to understand others and make his need known. The MDS further indicated Resident 21 supervision or touching assistance with eating; partial/moderate to substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated that Resident 21's AD was not completed. During a review of Resident 21's Advance Healthcare Directive (AHCD) Acknowledgement Form undated, the AHCD Acknowledgement Form was blank and did not indicate if the formulation of an AD was offered or discussed with Resident 21, if the resident was provided information, and the reason AD information was not provided, offered or discussed to Resident 21. During a concurrent interview and record review on 5/5/2026, at 1:55 p.m., with Social Services Director (SSD), Resident 21's medical record including social services notes, interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) care conference notes, progress notes, and undated AHCD Acknowledgement Form were reviewed. The SSD stated the AHCD Acknowledgement Form was blank and did not indicate if Resident 21 has previously formulated an AD, did not indicate if the resident/resident representative were provided the information on the formulation of advance healthcare directive, and also it did not indicate if Resident 21 refused to be provided with information, or was unable to sign. The SSD stated that the social services department was responsible in having the forms completed and filed in the paper chart. The SSD stated that Resident 21 did not have a representative and the facility is in the process of obtaining a public guardianship for Resident 21 as the resident did not have the capacity to understand and make decisions. The SSD stated that she (SSD) should have indicated in the AHCD Acknowledgement Form that she (SSD) attempted to discuss formulation of AD with Resident 21 and indicated in the form the reason the form was not completed. The SSD stated that not discussing the AD formulation and giving Resident 21 the chance to decline or accept formulation of an AD, the facility did not respect the resident's right to be informed to formulate an AD. The SSD stated that if the AHCD Acknowledgement Form was not completed, the staff would be unable to know what Resident 21's wishes were in the event of an emergency to prevent delay in care. During an interview on 5/7/2026, at 11:02 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that the SSD is responsible in making sure the resident and/or resident representative were asked upon admission if they have an AD, and the AHCD Acknowledgement Form was completed to reflect that formulation of an AD was discussed and offered, written information was provided, or if unable to sign (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the form. The ADON stated that the purpose of completion of the AHCD Acknowledgement Form was to ensure that the staff were aware of the resident's/representative's wishes in the event of an emergency. The ADON stated that if a resident did not have the capacity to make decisions as determined by the physician, the facility governing body will refer the resident for public guardianship. The ADON stated that Resident 21's AHCD Acknowledgement Form should have been completed by the SSD that formulation of an AD was discussed and offered, and provided written information, and indicate the reason why the form was not completed to ensure that all members of the IDT and nursing staff would be aware to prevent delay in care in case of an emergency. During a review of the facility's recent policy and procedure (P&P) titled Advance Healthcare Directives/POLST, last reviewed on 1/2026, the P&P indicated that the AHCD is to provide residents with the opportunity to make decisions regarding their healthcare and treatment options. The P&P further indicated: - At the time of admission, the admission staff or designee will inquire about the existence of an AHCD. - The facility will honor resident's AHCD and upon admission provide residents with information related to their right to execute and AHCD.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident was treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one of three sampled residents (Resident 64) reviewed for physical restraints by failing to ensure that Resident 64 did not have two pillows tucked on both sides under the fitted sheet. This deficient practice had the potential to result in the restriction of resident's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and death of residents. Findings: During a review of Resident 64's admission Record (AR), the AR indicated the facility origionally admitted the resident on 1/15/2026, and readmitted on [DATE], with diagnoses including muscle weakness, unspecified dementia (a progressive state of decline in mental abilities), anemia (a condition where the body does not have enough healthy red blood cells) and end-stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 64's History and Physical (H&P), dated 4/26/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 64's Minimum Date Set (MDS, a resident assessment tool), dated 4/29/2026, the MDS indicated the resident did not have the capacity to understand others and make self-understood. The MDS further indicated that Resident 64 required substantial or maximal assistance for personal hygiene, dressing, and repositioning, and was dependent on staff for bathing and all other activities of daily living (ADLs, routine task/activity such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 64's Care Plan (CP) titled, The resident is at risk for falls and injuries related to unsteady gait, ESRD (.), and The resident has had an actual fall from the wheelchair to transfer to the bed with no injury related to (r/t) non-compliance behavior, poor balance lack of coordination, risk taking behavior, unsteady gait (.) initiated on 4/30/2026, the CP indicated an intervention to assess and anticipate resident's needs: food, thirst, toileting needs, comfort level, body positioning, pain etc. During an observation on 5/04/2026 at 8:57 a.m. inside Resident 64's room, observed Resident 64 lying to her right side with eyes closed in bed. Observed pillows were tucked under Resident 64's fitted sheet on both sides of the bed. During a concurrent observation and interview on 5/04/2026 at 9:25 a.m., inside Resident 64's room, with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated that Resident 64 had pillows tucked under the fitted sheet. LVN 3 stated that the pillows are being used for repositioning and should be placed over and not tucked under the fitted sheet. LVN 3 stated that if a pillow is tucked under the fitted sheet, it is considered a form of a restraint because it is restricting the resident's movement. During a concurrent interview and record review on 5/7/2026 at 8:56 a.m. with Registered Nurse 1 (RN 1), RN 1 stated that Resident 64 does not have an order for restraints. RN 1 further stated that before putting a resident on restraints there should be a restraint assessment, change of condition, physician's order, consent, and care plan. RN 1 stated that when pillows are placed underneath the fitted sheet, it would restrict residents from moving freely. RN 1 stated that restricting the residents to move freely can cause entrapment in bed which can lead to anxiety and could affect skin integrity. During a concurrent interview and record review on 5/7/2026 at 10:39 a.m. with Assistant Director of Nursing (ADON), the ADON stated that before putting a resident on restraint, there should be physical assessment, physician order, consent and care plan. The ADON stated that if residents cannot move or remove any type of device that limits the movement is a form of restraint. The ADON stated that limiting the movement of the residents can cause entrapment in bed which can lead to injuries. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the P&P indicated that restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The P&P further indicated: -Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. -Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted, including: a. using bedrails to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility while in bed; b. tucking sheets so tightly that a bed-bound resident cannot move; c. placing a resident in a chair that prevents the resident from rising; and d. placing a resident who uses a wheelchair so close to the wall that wall prevents the resident from rising. -Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. the specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint.

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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 a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of two sampled residents reviewed for respiratory care by failing to implement a care plan on the use of Bilevel Positive Airway Pressure (BIPAP - a non-invasive device used to help people breathe more easily, typically while sleeping or in a hospital setting) when the physician order was not followed to rinse and air dry after each use. This deficient practice had the potential to result in a delay of nursing care for Resident 8. Findings: During a review of Resident 8's Face Sheet (FS), the FS indicated that the facility originally admitted the resident on 4/30/2024 and readmitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), obstructive sleep apnea (a disorder where breathing repeatedly stops and starts during sleep when the throat muscles relax and cause the airway to collapse and block airflow), and convulsions (a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body). During a review of Resident 8's History and Physical (H&P), dated 12/26/2025, the H&P indicated that the resident could make needs known, but cannot make medical decisions. During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2026, the MDS indicated the resident made self understood and had the ability to understand others. The MDS indicated Resident 8 was dependent on staff with eating, oral hygiene, toileting, shower/bathe self, lower body dressing, personal hygiene and mobility. The MDS indicated that a non-invasive mechanical ventilator (a breathing support system that delivers oxygen through a face mask over the nose or mouth) was performed while Resident 8 was a resident of the facility. During a review of Resident 8's physician order, dated 12/19/2025, the physician order indicated BiPAP order: Empty BiPAP distilled water chamber at end of each treatment, rinse with warm water and air dry in the morning. During a review of Resident 8's Care Plan (CP) titled, Resident on BiPAP at bedtime, dated 11/11/2025, the CP indicated the resident with goals to maintain normal breathing pattern with interventions including BiPAP order: Empty BiPAP distilled water chamber at end of each treatment, rinse with warm water and air dry. During a concurrent observation and interview on 5/4/2026 at 9:57 a.m. with Resident 8, at Resident 8's room, observed BiPAP water chamber with water droplets inside the chamber. Resident 8 stated that he uses his BiPAP machine every night because it helps him breathe and the staff removes it from him in the morning. Resident 8 stated the staff has not cleaned his BiPAP machine and his wife has spoken to the staff to clean it. During a concurrent observation and interview on 5/4/2026 at 3:22 p.m. with Licensed Vocational Nurse (LVN) 1, at Resident 8's room, observed BiPAP water chamber with water droplets inside. LVN 1 stated Resident 8 uses his BiPAP machine at night and in the morning the charge nurse removes the BiPAP mask from the resident. LVN 1 stated the night shift changes the BiPAP equipment and the day shift cleans the BiPAP machine. LVN 1 stated the water chamber is not supposed to have water condensation inside and it has to be dry. LVN 1 stated he did not clean Resident 8's BiPAP machine today. LVN 1 stated it has to be clean and dry to prevent water stagnation and prevent clogging. During an interview on 5/7/2026 at 2:22 p.m. with the Infection Preventionist (IP), the IP stated the purpose of cleaning the BiPAP after each use and air dry is to prevent any respiratory infection build-up of microorganisms and goes directly by inhaling and can cause respiratory issues.ˆThe IP stated the night shift if scheduled at 7 a.m., unless it was endorsed to the day shift and was unable to clean it then 7am-3 p.m./dayshift charge nurse needs to clean it.ˆ During an interview on 5/8/2026 at 11:12 a.m. with the Assistant Director of Nursing (ADON), the ADON stated when the BiPAP water chamber is emptied, air dry, there will be condensation at first but should dry out.ˆThe ADON stated the care plan was not implemented for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 8 when the BiPAP was not rinsed and air dried and condensation remained in the water chamber. The ADON stated the resident could develop respiratory infection and shortness of breath when the BiPAP is not cleaned and left dirty. During a review of the facility-provided BiPAP Machine (BPPM) User Guide, undated, the User Guide indicated to Regularly clean your tubing assembly, water tub (chamber) and mask to receive optimal therapy and to prevent the growth of germs that can adversely affect your health. 1. Wash the water tub and air tubing in warm water using only mild detergent. Do not wash in a dishwasher or washing machine. 2. Rinse the water tub and air tubing thoroughly and allow to dry out of direct sunlight and/or heat. 3. Wipe the exterior of the device with a dry cloth. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed and approved on 1/2026, the P&P indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 4. Each resident's comprehensive person-centered care plan will be consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to:. g. receive the services and/or items included the plan of care.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a comprehensive care plan for one of three sampled residents (Resident 49) reviewed for pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence) when the facility failed to revise Resident 49's care plan to reflect the physician's order to offload (relieve pressure) Resident 49's left foot for a stage one (1) pressure ulcer/injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness). This failure resulted in the lack of an individualized plan of care for Resident 49. Cross-reference F686.Findings: During a review of Resident 49's admission Record, the admission Record indicated that Resident 49 was originally admitted on [DATE] and was readmitted on [DATE] with a diagnoses of metabolic encephalopathy (brain dysfunction due to chemical imbalances, or infection); right-sided hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body); and dysarthria (slurred speech) following a cerebral infarction (brain injury). During a review of Resident 49's Minimum Data Set (MDS - a resident assessment tool), dated 4/23/2026, the MDS indicated that the resident has some mild cognitive impairment (mental status is not fully intact). The MDS indicated that Resident 49 requires supervision for eating, maximal assistance for oral hygiene and upper body dressing, and is dependent on toileting, showering and lower body dressing. The MDS indicated that Resident 49 has a stage 1 pressure ulcer on her left foot upon readmission to the facility. During a review of the physician's active orders, dated 4/20/2026, the physician order indicated Heel Protector(s) to left foot at all times. Use pillows to offload heel for pressure reduction, every shift for left heel pain. May remove during showers and activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily). The physician's order dated 4/20/2026 indicated that Resident's plan of care has been read and approved. Continue all orders for 45 days unless otherwise specified. During a review of Resident 49's Care Plan Report, dated 4/21/2026, the care plan indicated the following: Resident 49 was readmitted with a left heel stage 1 pressure injury. Left heel stage 1 pressure injury - Cleanse with normal saline (NS- a saltwater solution), pat dry, apply vitamin A&D ointment (a first-aid skin protectant typically used for minor scratches, cuts, and injuries) cover with silicone foam dressing (a wound care dressing) every day shift for 21 days until finished. During a concurrent observation and interview on 5/6/2026 at 10:33 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 did not place a pillow under Resident 49's left foot. CNA 1 stated that Resident 49 is supposed to have a pillow under her left foot so it will not touch the bed. During a concurrent interview and record review on 5/6/2026 at 11:16 a.m. with the MDS Coordinator (MDSC), Resident 49's care plans, dated 4/21/2026, and physician's orders were reviewed. The MDSC stated that Resident 49 had a stage 1 pressure injury upon readmission from the General Acute Care Hospital (GACH). The MDSC stated the care plan guides staff interventions and communication. The MDSC stated that a pillow is used to offload the resident's foot and should have been included in the care plan per the physician's order; however, it was not. The MDSC stated that missing information in the care plan may lead staff to miss required interventions. During a concurrent interview and record review with the Director of Nursing (DON) on 5/6/2026 at 11:28 a.m., the physician's orders were reviewed. The DON stated the pillow should be on the left heel at all times and only removed when the resident is being cleaned. The DON stated that the purpose of the pillows as an offloading device is to protect the skin. The DON stated that the nurses and CNAs know they must use the pillows as an offloading device. The DON stated the care plan is how the facility completes interventions, as it has resident-specific focuses and goals. The DON stated that the treatment nurse, and registered nurse (RN) must complete the care plan when a resident is admitted to the facility. The DON stated the MDSC also looks at the comprehensive care plan to verify accuracy. The DON stated that if the intervention is not in the plan (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of care, it is possible that the intervention is not being provided. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/2026, the P&P indicated, The comprehensive, person-centered care plan will: describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. The policy further indicated the interdisciplinary team must review and update the care plan.when the resident has been readmitted to the facility from a hospital stay.

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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, interview, and record review, the facility failed to prevent worsening of a pressure ulcer/injury stage 1 (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness) when one of three sampled residents (Resident 49) did not have a pillow under the left foot, per the physician's order. This failure had the potential to result in worsening of Resident 49's pressure ulcer. Cross-reference F657. Findings: During a review of Resident 49's admission record, the admission record indicated that the facility originally admitted Resident 49 on 11/05/2019 and was readmitted on [DATE] for metabolic encephalopathy (brain dysfunction due to chemical imbalances, or infection), right-sided hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), and dysarthria (slurred speech) following a cerebral infarction (brain injury). During a review of Resident 49's Minimum Data Set (MDS- a resident assessment tool), the MDS indicated that the resident had some mild cognitive impairment (mental status is not fully intact). The MDS indicated that Resident 49 required supervision for eating, maximal assistance for oral hygiene and upper body dressing, and was dependent for toileting, showering and lower body dressing. The MDS indicated Resident 49 had a stage 1 pressure ulcer on her left foot upon readmission to the facility. During a review of the physician's active orders dated 4/20/2026, the Physician's order indicated: Heel Protector(s) to left foot at all times. Use pillows to offload heel for pressure reduction, every shift for left heel pain. May remove during showers and ADLs. During an observation on 5/04/2026 at 1:26 p.m. in Resident 49's room, Resident 49 had no pillow underneath left foot. During an observation on 5/05/2026 at 12:00 pm, Resident 49 was observed eating lunch in her room with no pillow placed under the left foot. During a concurrent observation and interview on 5/06/2026 at 10:33 a.m. with the Certified Nursing Assistant 1 (CNA 1), Resident 49's left foot did not have a pillow underneath. CNA 1 stated Resident 49 should have a pillow under her left foot, so it was offloaded from the bed. CNA 1 stated that Resident 49's pressure ulcer could worsen if the wound comes into contact with the bed. CNA 1 stated that a pillow is used to offload pressure and prevent the development or progression of pressure ulcers, as the wounds can become infected if they worsen. During a concurrent interview and record review with the Treatment Nurse (TN 1) on 5/06/2026 at 10:42 am, TN 1 stated that Resident 49 receives treatment for the stage 1 pressure injury. TN1 stated pillows are used as heel protectors. TN1 stated all the CNAs are aware that the pillow needs to be in place for Resident 49. TN1 stated that without the pillow placed under the left foot, the resident is at risk for further skin breakdown and worsening of the pressure ulcer. During a concurrent interview and record review with the Director of Nursing (DON) on 5/06/2026 at 11:28 a.m., the DON stated that the physician's order indicated that the pillow should be on the left foot at all times and only be removed if the resident is being cleaned. DON stated that if the pillow is not there, the resident's pressure injury can worsen. DON stated TN1 is responsible for documenting that it has been completed, but the TN, nurses, and CNAs are responsible for making sure the task is done. During a review of the facility's undated policy and procedure (P & P) titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, the P& P indicated that nurse shall describe and document/report the following: current treatments, including support surfaces. During a review of the facility's P & P titled, Prevention of Pressure Injuries, dated 04/2020, the P & P indicated for Mobility/Repositioning that the facility will provide support devices and assistance as needed. Device-Related Pressure Injuries indicated the facility will review and select medical devices with consideration to the ability to minimize tissue damage . and monitor regularly for comfort and signs of pressure-related injury.

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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 residents received adequate supervision to prevent accidents by failing to: 1. Ensure oxymetazoline HCl nasal spray (a medication to treat congestion in the nasal passage) was not left unattended and readily available for self-administration in a resident's shared room for one of three sampled residents (Resident 15). This failure had the potential to result in residents obtaining medication without staff knowledge resulting in unsupervised self-administration and accidental ingestion causing harm to residents. 2. Ensure the right side floor mat was in place while the resident was in bed and left unattended for one of three sampled residents (Resident 10). This failure had the potential to result in Resident 10 being at risk for increased chances of incurring injury from falls resulting in fractures (a break or crack in a bone), hospitalization, and death. Cross-reference F554. Findings: a. During a review of Resident 15's Face Sheet (FS), the FS indicated the facility admitted the resident on 1/22/2026 and most recently admitted the resident on 2/20/2026 with diagnoses that included heart failure (a condition in which the heart cannot pump enough blood to meet the body's needs), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with one's daily functioning), and hypertension (high blood pressure). During a review of Resident 15's History and Physical (H&P), dated 2/21/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 15's Minimum Data Set (MDS - resident assessment tool), dated 2/25/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident required supervision for eating, partial / moderate assistance for oral hygiene, and was dependent on staff for toileting and bathing. During a review of Resident 15's Admission/readmission Initial Assessment for Self-Administration of Medications (AASAM), dated 2/21/2026, the AASAM indicated resident did not want to self-administer medications and no further assessment was completed. During a concurrent observation and interview on 5/4/2026 at 9:55 a.m., with Resident 15 in resident's shared room, observed a bottle of oxymetazoline HCl nasal spray sitting on the resident's bedside rolling table. Resident 15 stated he had allergies and used oxymetazoline HCl nasal spray whenever he needed it. During an observation on 5/4/2026 at 3:29 p.m., observed the oxymetazoline HCl nasal spray remained on Resident 15's bedside rolling table and was visible from the hallway. Observed Resident 15 was not in the shared room and no staff were present. During a concurrent observation and interview on 5/4/2026 at 3:32 p.m., with Resident 15 and Certified Nursing Assistant (CNA) 2, observed Resident 15 walked down the hallway carrying a shopping bag and entered his shared room where the oxymetazoline HCl nasal spray remained on the bedside rolling table, Resident 15 stated he had just returned. Observed CNA 2 then entered Resident 15's room and stated she did not notice the nasal spray when she was in the room before and she did not know why the resident needed the nasal spray. Resident 15 stated he had been using the nasal spray for about a month in the evenings for a stuffy nose. Observed CNA 2 exited the resident's room and the nasal spray remained at bedside. Resident 15 stated the nasal spray had always been on the bedside rolling table and nobody had ever said anything about it. During a concurrent interview and record review on 5/4/2026 at 3:43 p.m. with Licensed Vocational Nurse (LVN) 5, Resident 15's physician orders for 5/2026 were reviewed. LVN 5 stated he had just started his shift at 3 p.m. LVN 5 stated that the facility process for self-administration of a medication was there must be an order for self-administration of medication because the physician has to authorize that the resident is able to self-administer. LVN 5 stated Resident 15 did not have a physician's order for oxymetazoline HCl nasal spray or an order that the resident may self-administer the medication. LVN 5 stated without an order, the resident should not be self-administering oxymetazoline HCl nasal spray or storing the medication at bedside. During a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow-up concurrent observation and interview on 5/4/2026 at 4 p.m. with LVN 5, LVN 5 stated residents have the right to self-administer medication, and the facility protocol should be followed. LVN 5 stated all staff are responsible for checking the residents' environment for safety when they make rounds. LVN 5 stated when Resident 15 stored the nasal spray in view on the bedside table for self-administration, staff should have identified and removed the medication, notified the physician, and performed a self-administration of medication assessment, but they did not. LVN 5 stated it was important for the physician to be notified to ensure that the medication was not contraindicated, to obtain an order for administration, and ensure the medication was documented when administered. LVN 5 stated medications should never be left at bedside, even if a resident is safe for self-administration, because another confused resident may take the medication resulting in adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have). Observed LVN 5 entered Resident 15's room and removed the nasal spray. Observed Resident 15 stated to LVN 5 that he (Resident 15) had been using the nasal spray every night for about a month. During an interview on 5/5/2026 at 1:42 p.m. with LVN 3, LVN 3 stated she cared for Resident 15 on 5/4/2026 during the day shift. LVN 3 stated she (LVN 3) must have missed seeing the nasal spray on the resident's bedside rolling table. LVN 3 stated she should have caught the nasal spray stored on the table during rounds but did not. During a concurrent interview and record review on 5/8/2026 at 9:09 a.m., with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding self-administration of medications and resident safety and supervision was reviewed. The DON stated she was made aware that Resident 15 stored nasal spray at bedside for self-administration. The DON stated the facility has a process for when a resident expresses desire to self-administer medications that includes conducting a self-administration of medication assessment. The DON stated it was the responsibility of all the staff to make sure medications are not stored at bedside for self-administration and the medication should have been identified and was not. The DON stated nasal spray medication should not have been left at bedside because the resident may not be safe to self-administer and other residents could get the medication and drink it causing harm. The DON stated the facility was an institution and all medications needed to be stored safely and documented when administered to ensure the physician's orders are followed. The DON stated the facility P&P was not followed when Resident 15 had nasal spray at bedside potentially resulting in harm to residents. During a review of the facility P&P titled, Self-Administration of Medications, last reviewed on 1/2026, the P&P indicated, Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re?assessed periodically based on changes in the resident's medical and/or decision-making status. 4. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. 5. Residents who are identified as being able to self-administer medications are asked whether they wish to do so. 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed on 1/2026, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility-Oriented Approach to Safety.2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring, and reporting processes. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, Resident-Centered Approach to Safety. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision . b. During a review of Resident 10's FS, the FS indicated the facility admitted the resident on 4/17/2026 with diagnoses that included unspecified dementia (a progressive state of decline in mental abilities), displaced fracture of base of neck of left femur (a type of hip fracture), fracture of unspecified part of body of left mandible (lower jaw bone), unspecified fracture of upper end of left humerus (upper arm bone), urinary tract infection (UTI- an infection in the bladder/urinary tract), muscle weakness, lack of coordination, and history of falling. During a review of Resident 10's History and Physical (H&P), dated 4/19/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 10's MDS dated [DATE], the MDS indicated the resident was rarely / never able to understand others and was rarely / never able to make herself understood. The MDS further indicated that the resident had a fall in the last month prior to admission resulting in fracture. During a review of Resident 10's Care Plan (CP) titled, The resident is at risk for falls and injuries related to aging with balance problems with left hip fracture related to mechanical fall at home, initiated on 4/23/2026, the CP indicated interventions that included bilateral floor mats for prevention of injury from falls. During a review of Resident 10's Physician Order Summary, the Physician Order Summary indicated orders that included to provide bilateral floor mats for prevention of injury from falls, dated 4/20/2026. During an observation on 5/7/2026 at 8:40 a.m., in Resident 10's room, observed the resident lying in bed unattended by staff or visitors. Observed a floor mat placed up on its side and resting up against the closed bathroom door and wall. Observed an unoccupied chair at the right side of the bed and no floor mat in place. During an observation on 5/7/2026 at 9:20 a.m., in Resident 10's room, observed the resident continued lying in bed unattended by staff or visitors. Observed the floor mat remained placed on its side and resting up against the closed bathroom door and wall. Observed an unoccupied chair at the right side of the bed and no floor mat in place. During a concurrent observation and interview on 5/7/2026 at 9:30 a.m., with CNA 1 in Resident 10's room, observed the resident continued lying in bed and no floor mat was in place on the right side of the bed, CNA 1 stated she was the assigned CNA but she had not recently been in the room. CNA 1 stated CNA 3 placed the chair at bedside and moved the fall mat against the wall when CNA 3 fed Resident 10 at about 7:45 a.m. CNA 1 stated CNA 3 must have forgotten to remove the chair and replace the floor mat, but she should have because the resident frequently tried to get out of bed and was at high risk for injury from falls. During an interview on 5/7/2026 at 9:36 a.m. with CNA 3, CNA 3 stated she placed the fall mat against the door when she fed Resident 10 at approximately 8 a.m. CNA 3 stated she did not put the fall mat back at the right side of the bed because CNA 1 was going to continue feeding Resident 10. During a concurrent interview and record review on 5/7/2026 at 9:40 a.m. with Licensed Vocational Nurse (LVN) 6, Resident 10's physician orders were reviewed. LVN 6 stated Resident 10 had an order for a fall mat because the resident was a high risk for falls and the fall mats prevent injury from falls. LVN 6 stated the CNAs should have ensured the floor mat was in place as soon as they finished assisting with breakfast. LVN 6 stated the fall mat should always be in place when the resident is in bed and there is no staff in the room. During a concurrent interview and record review on 5/8/2026 at 9:09 a.m., with the DON, the facility P&P regarding fall prevention and resident safety and supervision were reviewed. The DON stated it was fine for staff to remove the fall mat, but they must put it back in place. The DON stated fall mats do not prevent falls, but they reduce the risk for injuries when falls occur. The DON stated the P&P was not followed when Resident 10's fall mat was not in place potentially resulting in resident fractures. During a review of the facility P&P titled, Falls and Fall Risk, Managing, last reviewed on 1/2026, the P&P indicated, Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	falling and to try to minimize complications from falling. 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls . During a review of the facility P&P titled, Safety and Supervision of Residents, last reviewed on 1/2026, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Facility-Oriented Approach to Safety. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Individualized, Resident-Centered Approach to Safety. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. 4.Implementing interventions to reduce accident risks and hazards shall include the following: a. Communicating specific interventions to all relevant staff; b. Assigning responsibility for carrying out interventions; . d. Ensuring that interventions are implemented.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure residents who were incontinent of bladder received services and assistance for one of one sampled resident (Resident 28) reviewed for urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to ensure the urinary catheter tubing did not have a dependent loop while hanging on the side of the bed. This deficient practice had the potential for Resident 28's urine not to flow freely, and which may lead to the development of a UTI. Findings: During a review of Resident 28's admission Record, the admission Record indicated the facility admitted the resident on 12/22/2025 with diagnoses including obstructive and reflux uropathy (a condition where urine cannot drain properly due to a blockage causing the urine to back up into the kidneys), lack of coordination, and generalized muscle weakness. During a review of Resident 28's History and Physical (H&P), dated 12/23/2025, the H&P indicated Resident 28 had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 3/29/2026, the MDS indicated Resident 28 had intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 28 was independent with bed mobility; required setup or clean-up assistance with eating and oral hygiene; substantial/maximal assistance with tub/shower transfers, showers, and toileting; partial/moderate assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 28 had an indwelling urinary catheter. During a review of Resident 28's Order Summary Report, dated 5/1/2026, the Order Summary Report indicated the following physician's order: - 12/23/2025 to 5/5/2026; revised 5/5/2026: Indwelling catheter: Insert or change indwelling catheter French (FR - a unit of measurement) 16 per five (5) milliliters (ml - a unit of measurement) to drainage bag. Change if with blockage/leakage/removal/dislodged as needed. Keep drainage bag below the bladder and keep the tubing free of dependent loops and kinks. Keep the bag above the floor every shift. - 4/3/2026: Indwelling Catheter: Monitor for signs and symptoms of possible urinary infection and notify the physician. Document zero (0) if none, FP for flank pain, SP for suprapubic pain, T for tenderness, CU for change in character of urine such as new bloody urine; foul smell of urine or change in urinary sediment, MC for mental change, or FC for functional change, worsening of status every shift. During an observation on 5/4/2026 at 10:19 a.m., inside Resident 28's room, observed Resident 28 lying in bed asleep. Observed Resident 28's urinary drainage bag hanging on the right side of the bed frame in the middle and the FC tubing had a dependent loop with urine present on the tubing. During a concurrent observation and interview on 5/4/2026 at 10:25 a.m. inside Resident 28's room with Licensed Vocational Nurse (LVN) 6, LVN 6 stated Resident 28's urinary catheter tubing had a loop preventing the urine from flowing freely into the bag. LVN 6 stated the urinary catheter tubing had urine in the loop with some white sediments. LVN 6 stated staff responsibility when it comes to care of urinary catheter is to ensure the bag is below the bladder, the bag had privacy cover, and there must be no kink or loop in the tubing. LVN 6 stated if there is a kink or loop the urine cannot flow freely and cause development of urine infection. LVN 6 stated Resident 28's urinary catheter tubing should not have a loop so the urine can flow freely and prevent backing up to the bladder which can cause development of UTI. During an interview on 5/7/2026 at 11:20 a.m., with the Assistant Director of Nursing (ADON). The ADON stated that for urinary catheter care, the staff are supposed to ensure the drainage bag is not touching the floor to keep the bag clean, monitor for signs and symptoms of UTI, application of an anchor to prevent accidental pulling of the tubing, and the urine should be free flowing, and notify the physician for any abnormalities. The ADON stated the staff are supposed to ensure the urinary catheter tubing should not be coiled or have a dependent loop because it prevents (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the urine to flow freely and can back flow. The ADON stated Resident 28's urinary drainage bag should have been properly placed on the side of the bed so the tubing will not be coiled or kinked as it had the potential for the urine not to flow freely and flow back into the bladder which could lead to development or UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, last reviewed on 1/2026, the P&P indicated that the purpose of the procedure is to prevent catheter-associated urinary tract infections. The P&P further indicated that to maintain unobstructed urine flow, check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks and to position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure residents receiving enteral feeding (EF - also known as tube feeding, a method of supplying nutrients directly into the stomach) received appropriate care and services to prevent complications of enteral feeding for one (1) of 1 sampled resident (Resident 73) reviewed for tube feeding when the water flush bag was not changed according to the manufacturer's recommendations.This deficient practice had the potential to result in altered nutritional status such as dehydration (when the body uses or loses more fluid than it takes in), malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients), and complications associated with enteral feeding such as gastrointestinal (GI - relating to stomach and intestines) problems such as abdominal pain and diarrhea.Findings: During a review of Resident 73's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 2/8/2021 and readmitted in the facility on 11/15/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and hypertension (high blood pressure).During a review of Resident 73's History and Physical (H&P), dated 11/16/2025, the H&P indicated Resident 73 did not have the capacity to understand and make decisions.During a review of Resident 73's Minimum Data Set (MDS - a resident assessment tool), dated 3/14/2026, the MDS indicated Resident 73 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and unable to understand and make her needs known. The MDS further indicated that Resident 73 required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated Resident 73 received GT feeding.During a review of Resident 73's Order Summary Report, dated 5/1/2026, the Order Summary Report indicated the following physician's orders: - 3/12/2026: Tube Feeding Formula (TFF) 1 via GT at 40 ml milliliters (ml - a unit of measurement) per hour for 20 hours for a total of 800 ml per 1200 kilocalories (kcal - a unit of measurement for energy or calories) per 24 hours, on at 2 p.m. and off at 10 a.m. or until dose is complete.- 3/12/2026: every shift flush GT with water at 40 ml per hour for 20 hours for a total of 800 ml, on at 2 p.m. and off at 10 a.m. or until dose is complete. During a review of Resident 73's care plan (CP) on tube feeding, initiated on 8/7/2022 and last revised on 3/21/2026, the CP indicated to change the administration set and observe the resident for signs and symptoms of dehydration (a condition when the body does not have enough water to function properly), nausea (a feeling of sickness and discomfort in the stomach), vomiting, diarrhea, reflux (a backward flow of stomach contents or acid into the esophagus [also known as food pipe]), and constipation as a few of the interventions for the resident remain free of side effects or complications related to tube feeding.During an observation on 5/4/2026 at 9:11 a.m. inside Resident 73's room, observed Resident 73 ?s Ware Flush (WF) 1 bag indicated a date of 5/3/2026 1:45 p.m.During a concurrent observation and interview on 5/4/2026 at 3:10 p.m. inside Resident 73's room with Licensed Vocational Nurse (LVN) 7, LVN 7 stated that Resident 73's WF 1 bag indicated a date of 5/3/2026 1:45 p.m. LVN 7 stated the water flush bags are changed together with the feeding formula bags whenever it was finished or 48 hours after start of infusion.During a concurrent interview and record review on 5/4/2026 at 3:20 p.m., with LVN 7, the manufacturer's recommendation for WF 1 bag was reviewed. LVN 7 stated that WF 1 bag manufacturer's recommendation indicated that the water flush bag cannot be used for more than 24 hours due to risk of bacterial contamination. LVN 7 stated that she did not know that the water flush bags cannot be used for more than 24 hours as the facility practice is to change the water flush bags together with the feeding formula bags when finished. LVN 7 stated that Resident 73's water flush bag should have been changed and if the water flush bag was not changed (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	as recommended by the manufacturer, it placed Resident 73 at risk for getting infection thru the GT.During a concurrent interview and record review on 5/7/2026 at 11:45 a.m., with the Assistant Director of Nursing (ADON), the manufacturer's recommendation for WF 1 bag was reviewed. The ADON stated that WF 1 bag manufacturer's recommendation indicated that due to the risk of bacterial contamination and overall system accuracy of the feeding system, do not use the feeding sets for greater than 24 hours. The ADON stated that the facility practice is to change the water flush bags together with the feeding formula bags when finished or no more than 48 hours from when the formula bag was started. The ADON stated that Resident 73's water flush bag should have been changed as recommended by the manufacturer and if the water flush bag was not changed as recommended by the manufacturer, it placed Resident 73 at risk for acquiring infection thru the GT due to the possibly contaminated water flush bag.During a review of the facility provided manufacturer's recommendation for WF 1 bag, dated 2021, the manufacturer's recommendation indicated that due to the risk of bacterial contamination and overall system accuracy of the feeding system, do not use the feeding sets for greater than 24 hours.During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Feeding via Continuous Pump, last reviewed on 1/2026, the P&P indicated that the procedure is for the use of a pump for enteral feedings. The P&P further indicated to refer to facility procedures for hang times and administration set changes.

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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 facilityˆfailed toˆensure respiratory careˆprovided to residents was consistent with professional standardsˆofˆpractice forˆtwo of two sampled residents (Resident 8 and 43) reviewedˆfor respiratory care by failing to:ˆ 1. Follow the physician orderˆto rinse andˆair-dryˆResidentˆ8'sˆBilevel Positive AirwayˆPressure (BIPAP, a non-invasive device usedˆto help people breathe more easily, typicallyˆwhile sleeping or in a hospital setting)ˆafter each use.ˆ 2. Ensure Resident 43's oxygen (O2) via nasal cannula (NC - a simple, two-pronged device that delivers extra oxygen to the nose) tubing was not touching the floor. These deficient practicesˆhad the potentialˆfor the residents to develop complications such as shortness of breath and respiratory infections.ˆ Cross-reference F656.ˆ Findings:ˆ a. During a reviewˆof Resident 8'sˆFace Sheet (FS), theˆFSˆindicated that the facility originally admitted the resident onˆ4/30/2024, and readmitted on [DATE], with diagnoses including chronic obstructive pulmonary diseaseˆ(COPD-a chronic lung disease causing difficulty in breathing), obstructive sleep apneaˆ(a disorder where breathing repeatedly stops and starts during sleep when the throat muscles relax and cause the airway to collapse and block airflow), andˆconvulsionsˆ(a condition in which muscles contract and relax quickly and cause uncontrolled shaking of the body).ˆ During a review of Resident 8's History and Physical (H&P), datedˆ12/26/2025, the H&Pˆindicatedˆthatˆresidentˆwas able toˆmake needs known, but could not make medical decisions.ˆ During a review of Resident 8's Minimum Data Set (MDS- a resident assessment tool), datedˆ2/6/2026, the MDS indicated the resident makesˆself-understoodˆandˆhad the ability toˆunderstand others.ˆThe MDS indicated the resident was dependent on staff withˆeating, oral hygiene, toileting, shower/bathe self, lower body dressing,ˆpersonalˆhygieneˆand mobility. The MDS indicatedˆthatˆa non-invasive mechanical ventilatorˆ(a breathingˆsupport system that deliversˆoxygenˆthroughˆa face mask over the nose or mouth)ˆwas performed while Resident 8 was a resident of theˆfacility.ˆ During a review of Resident 8's physician order, datedˆ12/19/2025, the physician orderˆindicatedˆBiPAPˆorder: EmptyˆBiPAPˆdistilled water chamber at end of each treatment, rinse with warm water and air dry in the morning.ˆ During a review of Resident 8'sˆCareˆPlanˆ(CP)ˆtitled, Resident onˆBiPAPˆat bedtime, dated 11/11/2025, the CP indicated a goal for the resident to maintain normal breathing pattern with interventions including BiPAPˆorder: EmptyˆBiPAPˆdistilled water chamber at end of each treatment, rinse with warm water and air dry.ˆˆ During a concurrent observation and interview onˆ5/4/2026 at 9:57ˆa.m., with Resident 8, inside Resident 8's room,ˆobservedˆBiPAPˆwater chamber with water droplets inside the chamber.ˆResidentˆ8ˆstatedˆthat he (Resident 8) uses hisˆBiPAPˆmachine every night because it helps him breathe better andˆthe staffˆremoves the machineˆin the morning. Residentˆ8ˆstatedˆthe staff has not cleaned hisˆBiPAPˆmachine and his wife has spoken to the staff to clean it.ˆ During a concurrent observation and interview onˆ5/4/2026 at 3:22 p.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 8's room,ˆobservedˆBiPAPˆwater chamber with water droplets inside.ˆLVN 1 stated Resident 8 uses hisˆBiPAPˆmachine at night and in the morning the charge (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nurse removes theˆBiPAPˆmask from the resident.ˆLVN 1ˆstatedˆthe night shift changes theˆBiPAPˆequipment and the day shift cleans theˆBiPAPˆmachine.ˆLVN 1ˆstatedˆthe water chamber is not supposed to have water condensation inside and itˆhas toˆbe dry. LVN 1ˆstatedˆhe (LVN 1) did not clean Resident 8'sˆBiPAPˆmachine today. LVN 1ˆstatedˆitˆhas toˆbe clean and dry to prevent water stagnation and prevent clogging.ˆ During an interviewˆonˆ5/7/2026ˆatˆ2:22ˆp.m. with the Infection Preventionistˆ(IP), the IPˆstatedˆthe purpose of cleaning theˆBiPAPˆafter each use and air dry isˆto prevent any respiratory infection build-up of microorganisms and goes directly by inhaling and can cause respiratory issues.ˆTheˆIPˆstatedˆthe night shift charge nurses are scheduled to clean by 7ˆa.m. If the task is endorsed to the day shift charge nurses and remains incomplete, then the morning shift charge nurse are responsible for cleaning it.ˆˆ During an interview onˆ5/8/2026ˆatˆ11:12ˆa.m., with the Assistant Director of Nursing (ADON), the ADON statedˆwhenˆtheˆBiPAPˆwaterˆchamber is emptied, condensation may be present at first, however, it shouldˆdry out overtime.ˆTheˆADONˆstatedˆthe care plan was not implemented for Resident 8ˆwhen theˆBiPAPˆwas not rinsed andˆairˆdriedˆand condensation remained in the water chamber. The ADON stated theˆresident could developˆrespiratory infection and shortness of breath when theˆBiPAPˆis not cleaned and left dirty.ˆˆ During a review of the facility-providedˆBiPAPˆMachineˆ(BPPM)ˆUser Guide,ˆundated, the User Guideˆindicatedˆthat Regularlyˆclean your tubing assembly, water tub (chamber)ˆand mask to receiveˆoptimalˆtherapy and to prevent the growth of germs that can adversely affect your health.ˆ1. Wash the water tub and airˆtubingˆin warm water using only mild detergent. Do not wash in a dishwasher or washing machine. 2. Rinse the water tub and airˆtubingˆthoroughly and allowˆto dryˆout of direct sunlight and/or heat. 3. Wipe the exterior of the device with a dry cloth.ˆ During a review of the facility's policy and procedure (P&P) titled, CPAP/BiPAPˆSupport, last reviewed and approved 1/2026, the P&Pˆindicatedˆthe purpose of this policy is to promote resident comfort and safety. The P&Pˆindicatedˆtheˆpreparation included Review and follow manufacturer's instructions for CPAP machine setup and oxygen delivery.ˆ1. These are general guidelines for cleaning. Specific cleaning instructions are obtained from the manufacturer/supplier of the PAP device. 2. These guidelines are for single-resident use cleaning.ˆ b. During a review of Residentˆ43's FS, the FS indicated the facilityˆoriginallyˆadmitted Residentˆ43ˆonˆ8/21/2025, and readmitted in the facility onˆ4/23/2026,ˆwith diagnoses including COPD, congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), andˆdementia (a progressive state of decline in mental abilities).ˆ During a review of Residentˆ43's H&P datedˆ4/24/2026, the H&PˆindicatedˆResidentˆ43ˆdid not haveˆthe capacity to understand and make decisions.ˆ During a review of Residentˆ43's MDS, dated [DATE], the MDS indicated Residentˆ43ˆhadˆseverely impairedˆcognition (mental action or process ofˆacquiringˆknowledge and understanding) andˆrarely/neverˆunderstandsˆandˆmakesˆher needs known. The MDS furtherˆindicatedˆResidentˆ43ˆwasˆtotally dependentˆfrom staffˆwith all activities of daily living (ADLs - basic tasks that must beˆaccomplishedˆevery day for an individual to thrive). The MDS indicated Residentˆ43ˆreceived oxygen therapy while in the facility.ˆ (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Residentˆ43's Order Summary Report datedˆ5/1/2026, the Order Summary Reportˆindicatedˆa physician's order datedˆ4/24/2026ˆfor continuousˆoxygen at two (2) liters per minute via NCˆevery shift.ˆ During a review of Resident 43's CP on oxygen therapyˆinitiatedˆon 1/26/2026 and revised on 2/24/2026, the CPˆindicatedˆto administer oxygenˆcontinuouslyˆas one of the interventionsˆin order forˆthe residentˆto have no signs and symptoms of poor oxygen absorption.ˆ During a concurrent observation and interviewˆon 5/4/2026 at 9:22 a.m.ˆinside Residentˆ43's room with Certified Nursing Assistant (CNA) 4,ˆobservedˆResident 43 asleep in bed with oxygen therapy at two (2) liter per minute via NC andˆCNAˆ4ˆstatedˆthatˆResidentˆ43's oxygen tubing was touching the floor. CNAˆ5ˆstatedˆthat the staffˆhave toˆmake sure that all nasal cannula tubing should be kept off the floor by placing the extra tubing that may touch the floor inside the plastic storage bag always hanging on the side of the oxygen concentrator machine prior to leaving the room.ˆCNA 4 stated that the facility started usingˆVelcroˆ(a fastening system using two fabric strips)ˆstrap to secure the tubing on the side rail to keep the tubing off the floor.ˆCNA 4ˆstatedˆshe (CNA 4) did not know what happened with the Velcro strap.ˆCNAˆ4ˆstated that theˆVelcro strap should have been in place to secure theˆoxygen tubingˆso itˆshould notˆtouchˆthe floor atˆany timeˆas the floor is dirtyˆandˆcanˆcontaminate the tubing.ˆ During an interview onˆ5/7/2026 at 9:01 a.m. withˆthe Director of Staff Development (DSD),ˆthe DSDˆstatedˆthat the oxygen should not be touching the floor at any time.ˆThe DSDˆstatedˆthat the facility started implementing the use of Velcro strap to secureˆthe NC tubing in placeˆto prevent the tubing from touching the floor.ˆThe DSDˆstatedˆthat the nursingˆstaffˆshould ensure that the Velcro strapˆis in place and the NC tubing secured and off the floor prior to leaving the room. The DSDˆstatedˆthat CNA 4 should have ensuredˆthatˆthe Velcro strap was in place or get aˆreplacementˆVelcroˆstrap if missing to secure Resident 43's NC tubing in place to prevent the tubing from touching the floor. The DSDˆstatedˆthat the floor was dirty and contaminated the tubingˆwhich could lead to Resident 43 acquiring infectionˆfrom the contaminated tubing.ˆ During an interview onˆ5/7/2026ˆ11:29 a.m., with theˆADON, theˆADON stated thatˆthe facility started implementing theˆpractice that the nursing staffˆuseˆaˆVelcro strap to secure the NC tubing on the side rail to prevent the tubing fromˆtouching the floorˆand contamination.ˆThe ADON stated that the staff are supposed to ensure that NC tubingˆshould beˆkept off the floor at all timesˆprior to leaving the room.ˆThe ADON stated that CNA 4 should have ensuredˆthat the Velcro strapˆwas in place or replace it when missing to secure Resident 43's NC tubing in place and prevent the tubingˆfrom touching the floor.ˆThe ADON stated that the floor was dirtyˆand contaminated the NC tubing and may lead to Resident 43 acquiring infectionˆfrom the contaminated tubing.ˆ During a review of the facility's P&P titled, Oxygen Administration, last reviewed onˆ1/2026, the P&Pˆindicatedˆthat the purpose of theˆprocedureˆis to provideˆguidelines for the safe administration of oxygen. The P&P furtherˆindicatedˆoxygen tubing shall be stored in a designated plastic bag.ˆ During a review of the facility's P&P titled Infection Preventionˆand Control Programˆ(IPCP), last reviewed on 1/2026, the P&P indicatedˆanˆIPCP is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The P&P further indicatedˆthat some of the important facets of infection prevention include identifying possible infections or potential complications or dissemination, instituting measures to avoid complications or dissemination, educating staff and (continued on next page)

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Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ensuring they adhere to proper techniques and procedures, and communicating the importance of standard precautions and respiratory hygiene.^

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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. Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%) due to seven (7) errors observed out of 29 total opportunities (error rate of 24.14 %) for one of five sampled residents (Resident 23) observed during the Medication Administration Task. The medication errors occurred when Licensed Vocational Nurse (LVN) 3 crushed (pressing very hard so that the shape is destroyed and forms a soft powder) and administered seven crushed medications to Resident 23 without a physician's order on 5/6/2026 during the 9 a.m. routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely). These failures had the potential to result in Resident 23 experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and the potential to result in a negative impact to Resident 23's health and well-being. Cross-reference F755. Findings: During a review of Resident 23's Face Sheet (FS - admission Record), the FS indicated the facility originally admitted the resident on 2/9/2024 and most recently admitted the resident on 11/24/2025 with diagnoses that included chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), hypertension (HTN - high blood pressure), unspecified dementia (a progressive state of decline in mental abilities), and major depression (persistent feelings of sadness and loss of interest that can interfere with daily living). During a review of Resident 23's History and Physical (H&P), dated 11/25/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. The H&P further indicated the resident had additional diagnoses of metabolic encephalopathy (an alteration in consciousness due to brain dysfunction), moderate protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), and dysphagia (difficulty swallowing). During a review of Resident 23's Minimum Data Set (MDS - a resident assessment tool), dated 2/17/2026, the MDS indicated the resident rarely / never was able to understand others and rarely / never was able to make himself understood. The MDS further indicated the resident was dependent on staff for eating, toileting, bathing, personal and oral hygiene, dressing, and mobility. During a review of Resident 23's Care Plan (CP) titled, The Resident has an alteration in neurological status related to metabolic encephalopathy, dementia, elevated ammonia (a chemical made by bacteria in the intestines) level, initiated 11/27/2025, the CP indicated interventions that included to adjust the diet to accommodate chewing, swallowing or eating issues and to give medications as ordered. During a review of Resident 23's Physician Order Summary, the Physician Order Summary indicated the following orders: 1. Amlodipine Besylate (medication to treat HTN) oral tablet five (5) milligrams (mg, a unit of measurement) give one (1) tablet by mouth 1 time a day for HTN, dated 11/24/2025. 2. Ascorbic acid (vitamin C, a dietary supplement) tablet 500 mg, give 1 tablet by mouth two times a day for supplement, dated 1/26/2025. 3. Memantine HCL (medication to treat symptoms of dementia) oral tablet 10 mg, give 1 tablet by mouth 1 time a day related to unspecified dementia for seven (7) days, dated 4/30/2026. 4. Multi-vitamin with minerals (a dietary supplement) oral tablet, give 1 tablet by mouth 1 time a day for supplement, dated 11/25/2025. 5. Oyster shell calcium / vitamin D (a dietary supplement to treat low levels of calcium) tablet 500 - 200 mg-unit, give 1 tablet by mouth two times a day for supplement, dated 11/24/2025. 6. Rifaximin (an antibiotic that reduces ammonia production) oral tablet 550 mg, give 1 tablet by mouth two times a day for hyperammonemia (high levels of ammonia in the blood), dated 3/18/2026. 7. Sertraline HCL (medication used to manage and treat major depressive disorder) oral tablet, give 25 mg by mouth one time a day for depression manifested by verbally expressing sadness, dated 3/7/2026. During a Medication Administration Observation on 5/6/2026 at 8:17 a.m. with LVN 3, LVN 3 stated she would prepare Resident 23's 9 a.m. medications at Station 1 Medication Cart 1. LVN 3 stated Resident 23 was on a pureed diet (texture-modified foods for those who can't handle solid food due to chewing or swallowing difficulties) and she (LVN 3) will crush the medications and administer them with apple (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sauce. LVN 3 crushed the following medications: amlodipine tablet 5 mg, ascorbic acid tablet 500 mg, memantine HCL tablet 10 mg, multi-vitamin with minerals tablet, oyster shell calcium / vitamin D tablet 500 - 200 mg, rifaximin tablet 550 mg, and sertraline HCL tablet 25 mg. LVN 3 then entered Resident 23's room and administered the crushed medications with applesauce. During a follow-up concurrent interview and record review on 5/6/2025 at 12:54 p.m. with LVN 3, Resident 23's physician orders were reviewed. LVN 3 stated she (LVN 3) crushed Resident 23's medications because there was an order to crush them and it would not be safe for the resident to swallow the medications whole. LVN 3 then reviewed Resident 23's physician's orders and noted there was no order indicating to crush medications. LVN 3 stated she should have checked for an order to crush the medications prior to administering them to Resident 23, but she did not. LVN 3 stated she assumed Resident 23 had an order to crush the medications. LVN 3 stated when Resident 23's medications were crushed and administered without an order, there was potential to crush and administer a medication that should not be crushed. During a concurrent interview and record review on 5/6/2026 at 1:47 p.m. with the Director of Nursing (DON), facility policy and procedure (P&P) regarding medication administration and crushing medications were reviewed. The DON stated the facility process for administering crushed medications is that a physician's order is required prior to crushing and administering the medication. The DON stated if a resident has difficulty swallowing then the nurse should contact the physician for an order to crush the medications. The DON stated a physician's order is required to crush medication because a nurse is altering the medication when a tablet is crushed and all resident care requires an order. The DON stated not all medications can be crushed because altering the tablet may change a medications action on the body resulting in adverse effects. The DON stated when LVN 3 crushed and administered Resident 23's medication without a physician's order the facility P&P was not followed resulting in medication errors with the potential for side effects in Resident 23. During a review of the facility P&P titled, Medication Administration - General Guidelines, last reviewed 1/2026, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedure - Preparation: . Prior to administration, the medication and dosage schedule on the resident's MAR [Medication Administration Record - a daily log used by healthcare professionals and caregivers to track exactly what medicines a resident takes, when they take them, and who gave them the medication] is compared with the medication label. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines:. Long-acting or enteric coated dosage forms should generally not be crushed; an alternative should be considered. Procedure - Administration:. Medications are administered in accordance with written orders of the attending physician. During a review of the facility P&P titled, Crushing Medications, last reviewed 1/2026, the P&P indicated, Medications shall be crushed only when it is appropriate and safe to do so, consistent with physician orders. The medical director and director of nursing services, in conjunction with the consultant pharmacist, shall identify appropriate indications and procedures for crushing medications. In addition, the following guidelines shall be followed when crushing medications: . a. The MAR or other documentation must indicate why it was necessary to crush the medication.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure the resident's food preference was honored for one (1) out of five (5) sampled residents (Resident 43) reviewed during dining observation task by failing to ensure Resident 43 was provided food that accommodated the resident's preferences when the resident was not served ice cream as indicated in the meal ticket. This deficient practice placed Resident 43 at risk for decreased food intake which could potentially result in weight loss. Findings: During a review of Resident 43's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility originally admitted Resident 43 on 8/21/2025 and readmitted in the facility on 4/23/2026 with diagnoses including dysphagia (difficulty swallowing), adult failure to thrive (a decline caused by chronic diseases and functional impairments which, can cause weight loss, decreased appetite, poor nutrition, and inactivity) and dementia (a progressive state of decline in mental abilities). During a review of Resident 43's History and Physical (H&P), dated 4/24/2026, the H&P indicated Resident 43 did not have the capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 4/29/2026, the MDS indicated Resident 43 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and rarely/never understands and makes her needs known. The MDS further indicated Resident 43 was totally dependent from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 43 was on mechanically altered diet and did not have a history of weight loss in the last six (6) months. During a review of Resident 43's Order Summary Report, dated 5/1/2026, the Order Summary Report indicated a physician's order: - 4/23/2026: Regular diet 4 - Pureed texture (consists of foods blended, mashed, or strained into a smooth, thick, pudding-like texture that requires no chewing), thin liquid consistency. - 4/30/2026: High protein nourishment sugar free (HPN - a nutritious drink that supports muscle health and provide extra vitamins which a person cannot get from regular food) three times a day. During a review of Resident 43's care plan (CP) on unavoidable weight loss, initiated on 4/9/2026 and last revised on 5/4/2026, the CP indicated to honor resident preferences and give the resident supplements as ordered a s a few of the interventions in place for the resident to consume at least 50 percent (% - a unit of measurement) two (2) to three (3) meals a day. During a review of Resident 43's meal ticket, dated 5/4/2026, the meal ticket indicated to add ice cream. During a concurrent observation and interview on 5/4/2026 at 12:49 p.m. with Registered Nurse (RN) 3 during dining observation in Dining Room (DR) 2, RN 3 stated Resident 43's meal ticket indicated to add ice cream, but the resident was not served ice cream in the lunch tray. RN 3 stated that Resident 43's ice cream was overlooked and was missing during inspection of meal trays prior to distribution to the residents. RN 3 stated that when checking the resident's tray or food being served, the diet list is compared with the resident's meal tray and the meal ticket to ensure all the items listed in the meal ticket were served. RN 3 stated Resident 43's ice cream should have been served to assist the resident with increased intake when eating a food preference. During a concurrent interview and record review on 5/7/2026 at 10:39 a.m. with the Assistant Director of Nursing (ADON), a photograph of Resident 43's meal ticket and meal served for lunch on 5/4/2026, physician's orders, CP, and dietary or nutritional progress note, dated 4/10/2026, were reviewed. The ADON stated that the photograph indicated the meal ticket for 5/4/2026 lunch service indicated to add ice cream, but the photograph did not show that the ice cream was served to Resident 43. The ADON stated the physician's order did not indicate ice cream. The ADON stated the dietary/nutritional progress notes dated 4/10/2026 indicated that the Dietary Supervisor (DS) offered ice cream to the resident for lunch and the resident agreed. The ADON stated that meal trays are checked by 2 licensed nurses by comparing the diet list with meal tray and meal ticket to ensure the residents received the food that (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was in the menu and that their food preferences were honored to help increase their food intake and prevent weight loss. The ADON stated that Resident 43 should have been served the ice cream as indicated in the meal ticket to help assist in increasing Resident 43's food intake and prevent further weight loss. During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, last reviewed on 1/2026, the P&P indicated individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. The P&P indicated nursing staff will document the resident's food and eating preferences in the care plan. During a review of the facility's P&P titled, Food and Nutrition Services, last reviewed on 1/2026, the P&P indicated that each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. The P&P further indicated: - The multidisciplinary staff, including nursing staff, the attending physician and the dietitian will assess each resident's nutritional needs, food likes, dislikes, and eating habits, as well as physical, functional, and psychosocial factors that affect eating and nutritional intake and utilization. - Reasonable efforts to accommodate these choices and preferences are addressed by facility staff. - Food and nutrition services staff will inspect food trays to ensure that the correct meal is provided to each resident.

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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 ensure safe and sanitary food storage and food preparation practices in the kitchen by failing to discard one (1) yellow bell pepper with white and gray discoloration inside a green tray. This deficient practice had the potential to result in harmful bacterial growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 90 out of 92 medically compromised residents who received food from the kitchen. Findings: During a tour of the walk-in refrigerator on 5/4/2026 at 8 a.m. with the Dietary Supervisor (DS), observed inside the walk-in refrigerator 1 yellow bell pepper with gray and white discoloration. During a concurrent observation and interview on 5/4/2026 at 8:05 a.m., the DS stated that vegetables and other food items are checked regularly. The DS stated that the yellow bell pepper had been in the green tray and should have been discarded. The DS stated that the yellow bell pepper cannot be used anymore since there is a sign of rotting. The DS further stated that if ingested, it can cause gastrointestinal (GI - parts of the body responsible for digestion) problems. During an interview on 5/8/2026 at 2:15 p.m. with the Director of Nursing (DON), the DON stated that vegetables and other food items are inspected every day. The DON stated that it can be cut and properly washed or must be thrown away. The DON stated that any vegetables with signs of spoilage if ingested may cause GI upset. During a review of facility's policy and procedure (P&P) titled, General Receiving of Delivery of Food and Supplies, with year 2025 indicated, Food deliveries will be inspected to assure high quality food and supplies. They are to be received in proper conditions. - Carefully inspect deliveries for proper handling, labeling, temperature and appearance. - Produce is to be fresh and free of any wilting or spoilage.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on observation, interview, and record review, the facility failed to ensure necessary care was provided consistently for a resident who was receiving hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) for one of one sampled resident (Resident 52) reviewed under hospice care area by failing to: 1. Ensure Resident 52's hospice plan of care was followed for hospice aide visit once a week when the hospice aide (HA) did not visit on 2/13/2026 and 2/20/2026. 2. Ensure Resident 52's Registered Nurse (RN) Visit Note did not indicate that a hospice aide evaluation was completed on 2/13/2026. These deficient practices had the potential to negatively affect Resident 52's physical comfort, psychosocial well-being, and had the potential to result in a delay or lack of necessary care and services. Findings: During a review of Resident 52's Face Sheet (FS), the FS indicated that the facility admitted the resident on 9/25/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), encephalopathy (a broad term describing any disorder or disease that affects the brain's structure or function, leading to impaired brain function). During a review of Resident 52's History and Physical (H&P), dated 9/27/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 52's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2026, the MDS indicated the resident makes self understood and has the ability to understand others. The MDS indicated the resident required staff assistance with activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) and mobility. The MDS indicated hospice care was performed for Resident 52 while a resident of the facility. During a review of Resident 52's physician order, dated 2/9/2026, the physician order indicated admitted to Hospice Service (HS) 1 under routine level of care. During a review of Resident 52's initial Hospice Certification (a document in which the physician certifies the resident is terminally ill with a prognosis of six months or less) and Plan of Care (POC), dated 2/8/2026, the Hospice Certification and POC indicated a certification period from 2/6/2026 to 5/6/2026 did not have the resident's hospice aide frequency of visit. During a review of Resident 52's hospice order, dated 2/10/2026, the hospice order indicated Certified Home Health Aide (CHHA) once per week for 12 weeks, effective 2/8/2026. During a concurrent interview and record review on 5/8/2026 at 9:22 a.m. with the Assistant Director of Nursing (ADON), Resident 52's hospice calendars, hospice aide and RN Visit Note Report, and Multidisciplinary notes for the month of 2/2026 were reviewed. The ADON stated she was unable to locate the hospice aide notes for dates 2/13/2026 and 2/20/2026. The ADON stated the HA visit notes on file started on 2/25/2026. During a follow-up interview and record review on 5/8/2026 at 11:36 a.m. with the ADON, Resident 52's RN Visit Note, dated 2/13/2026, and HA Visit Notes were reviewed. The ADON stated the hospice care provides services to the resident that met the criteria nearing end of life to provide comfort. The ADON stated the purpose of the hospice plan of care provides the facility a communication tool for all healthcare providers including the facility and the hospice company, HS 1. The ADON stated the RN Visit Note, dated 2/13/2026, indicated that the hospice aide evaluation of care was completed even though the HA visit notes they have started 2/25/2026. The ADON stated when the hospice plan of care is not followed and not properly communicated the facility, resident, and representative could potentially assume that care was provided. The ADON stated the facility CNAs assigned to Resident 52 could potentially not give the proper care that the resident required for their physical comfort and well-being. During a follow-up interview on 5/8/2026 at 12:54 p.m. with the ADON, the ADON stated they received today, 5/8/2026, the hospice aide report and addendum to the RN Visit Note Report, dated 2/13/2026, there was no HA evaluation done by the RN. The ADON stated this should have been provided right away in 2/2026. The ADON stated there was no documentation that it was noted and (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed up with HS 1. The ADON stated the HA visits were missed on 2/13/2026 and 2/20/2026. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, last reviewed and approved on 1/2026, the P&P indicated that Hospice services are available to residents at the end of life. 5. Hospice providers who contract with the facility:. b. are held responsible for meeting the same professional standards and timeliness of service as any contracted individual or agency associated with the facility. 9. In general, it is the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following: a. Determining the appropriate hospice plan of care; b. Changing the level of services provided when it is deemed appropriate.

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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, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for one (1) of 1 sampled resident (Resident 89) reviewed under infection control care area by: 1. Failing to ensure there was a physician's order for the Enhanced Barrier Precaution (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO - microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics (medication used to treat bacterial infections)] that uses targeted gown and glove use during high contact resident care activities) due to presence of wound on the left foot. 2. Failing to ensure the EBP sign was posted by the door outside the resident's room. These deficient practices had the potential to spread infections and illnesses to residents, visitors, and staff. Findings: During a review of Resident 89's admission Record, the admission Record indicated the facility admitted the resident on 12/10/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), absence of left great toe, and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 89's History and Physical (H&P), dated 12/15/2025, the H&P indicated Resident 89 did not have the capacity to understand and make decisions. During a review of Resident 89's Minimum Data Set (MDS - a resident assessment tool), dated 3/13/2026, the MDS indicated Resident 89 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) was usually able to understand others and make his needs known. The MDS further indicated Resident 89 required setup or clean-up assistance with eating; partial/moderate assistance with oral hygiene, upper body dressing, and bed mobility; total assistance with tube/shower transfer; substantial/maximal assistance from staff with all other 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 89's Order Summary Report dated 5/2/2026, the Order Summary Report indicated the following physician's orders: - 4/22/2026: Left medial heel diabetic wound - Cleanse with ns (NS - a saltwater solution), pat dry, paint with betadine (a topical [on the surface] solution used to treat and prevent infections), apply ABD pad (used to absorb discharges from heavily draining wounds), wrap with sterile bandage roll every day shift for 21 days. - 4/27/2026: Santyl external ointment (a medication that is primarily used to remove dead or damaged tissue from chronic wounds promoting healthy skin growth) 250 unit per gram (unit/gm - a unit of measurement) apply to left lateral plantar foot (bottom part of foot) topically every day shift for wound healing for 30 days. - 4/27/2026: Left lateral plantar foot diabetic wound - Cleanse with NS, pat dry, apply Santyl ointment, apply collagen matrix (a type of advanced wound care dressing), apply ABD pad, wrap with sterile gauze bandage roll every day shift for 30 days. During an observation on 5/4/2026 at 11:09 a.m., outside Resident 89's room, observed a blue EBP sign at the door. Observed a blue colored round sticker next to Resident 89's roommate's name. During a concurrent observation and interview on 5/4/2026 at 11:10 a.m. inside Resident 89's room, Resident 89 was lying in bed awake, able understand and communicate, with the left foot wrapped with gauze bandage roll. Resident 89 stated that he is diabetic and he had two wounds on his left foot for a few months now but was unable to recall how many months. During a concurrent observation, interview, and record review on 5/5/2026 at 8:45 a.m. outside Resident 89's room, with the Infection Preventionist (IP), Resident 89's physician's orders were reviewed and the EBP sign outside the door was observed. The IP stated that Resident 89 had diabetic wounds on the left foot. The IP stated there was no physician's order to place Resident 89 on EBP due to the presence of wounds and there was no blue sticker next to Resident 89's name at the door to identify him that he requires EBP. The IP stated diabetic wounds that have discharges, draining, and/or wrapped with gauze bandage roll should be placed on EBP and place a blue round sticker next to the resident's name and the staff have (continued on next page)

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	555012	A. Building B. Wing	05/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Valley Village Care Center	13000 Victory Blvd North Hollywood, CA 91606

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to wear the proper personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) during high contact activities to prevent the spread of infection to other residents and staff. The IP stated that Resident 89 should have been placed on EBP by obtaining an order from the physician and placing a blue round sticker next to Resident 89's name at the door to prevent the spread of infection to and from other resident and staff. During an interview on 5/7/2026 at 11:35 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that residents with indwelling devices such as gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), urinary catheter (a hollow tube inserted into the bladder to drain or collect urine), and draining wounds should have a physician's order for EBP, should have an EBP sign posted and a blue round sticker next to the resident's name at the door to identify them that the staff have to wear the proper PPE after performing hand hygiene during high contact activities. The ADON stated that she was made aware that Resident 89 did not have a physician's order and there was no blue round sticker next to Resident 89's name to identify him that the resident was on EBP. The ADON stated that a physician's order for EBP should have been obtained and a blue round sticker next to Resident 89's name as it the potential to spread infection to other residents and staff. The ADON stated that the staff would not be aware Resident 89 was on EBP and would not wear the proper PPEs when taking care of the resident. During a review of the facility's policy and procedure (P&P) titled, Standards Precautions, Enhanced Barrier Precautions, and Transmission based Precautions, last reviewed on 1/2026, the P&P indicated that the policy is to provide guidelines for infection control practices to reduce the potential for transmission of infection including MDROs and viruses. The P&P further indicated: - The risk factors include close contact/exposure to an active infection, non-intact skin sites, and presence of invasive devices such as GT, urinary catheters, nasogastric tubes, vascular access lines (a thin, flexible tube placed into a blood vessel to easily give medicines, fluids, or nutrients into the bloodstream, or take blood samples), tracheostomy (a hole made by a surgeon through the front of the neck and into the windpipe, insert a tracheostomy tube to keep the airway open). - Enhanced barrier Precautions (EBP): The use of gowns and gloves for specific high contact activities based on the resident's characteristics associated with a high risk for MDRO colonization and transmission: presence of indwelling medical devices, chromic and open non-healing wounds. Gowns and gloves will be used while performing high-contact tasks associated with the risk for MDRO contamination of staff hands, clothes, and the environment: morning and evening care, device care, ADLs, changing bed linens, and any care activity involving contact with environmental surfaces.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	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 ensure an accurate assessment was conducted for one of one sampled resident (Resident 72) reviewed during the Position, Mobility care area and one of two sampled residents (Resident 31) by: 1. Failing to ensure the Minimum Data Set (MDS - a resident assessment tool) Assessment was coded correctly to indicate the restorative nursing staff provided the application and removal of splint for Resident 72. This deficient practice had the potential to result in missed interventions. 2. Failing to ensure the MDS Assessment was transmitted accurately when Resident 31 who did not receive an antibiotic (a type of medication that treats bacterial infections) was coded as taking the medication. This deficient practice had the potential to cause confusion and delay in the delivery of necessary care and services to Resident 31. Findings: a. During a review of Resident 72's Face Sheet (FS – admission Record), the FS indicated that the facility originally admitted the resident on 9/26/2021 and readmitted on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-damage to tissues in the brain due to a loss of oxygen to the area) affecting left non-dominant side, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of left hand muscle, and dementia (a progressive state of decline in mental abilities). During a review of Resident 72's History and Physical (H&P), dated 10/10/2025, the H&P indicated that the resident has the capacity to understand and make decisions. During a review of Resident 72's physician orders, the physician orders indicated Restorative Nursing Assistant (RNA) to apply bilateral knee splint daily seven (7) times per week for 4 hours or as tolerated, every day shift – document total number of hours tolerated. During an observation on 5/7/2026 at 9:11 a.m. with RNA 1, at Resident 72's bedside, RNA 1 provided range of motion (ROM) exercises to Resident 72's bilateral upper extremities and bilateral lower extremities. During a concurrent observation and interview on 5/7/2026 at 9:28 a.m. with RNA 1, at Resident 72's bedside, RNA 1 applied splints to Resident 72's left and right knees. RNA 1 stated the splints are on for four hours. RNA 1 stated the order is to apply the splints seven days a week for four hours and Resident 72 has been tolerating it. During a concurrent interview and record review on 5/7/2026 at 11:08 a.m. with the MDS Coordinator (MDSC), Resident 72's physician orders, RNA treatment record for the month of 3/2026, and MDS Assessment, dated 3/30/2026, were reviewed. The MDSC stated that the RNA treatment for the month of 3/2026 indicated RNA applied both knee splints every day for four hours and Resident 72 did not have any missed treatments. The MDSC stated it should be coded for 7 days and that she will submit a modification for the splint coding. The MDSC stated it should be coded accurately so they can give the care that Resident 72 needs. During an interview on 5/8/2026 at 11:22 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the MDS Assessment is important because it transmits to Centers for Medicare & Medicaid Services (CMS - a federal agency that administers major healthcare programs) and is a legal document and show how they treat the resident by not coding it properly not accurate. The ADON stated CMS could potentially not see the full assessment of the resident. The ADON stated it can also (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	show that the resident has limited range of motion and is not receiving services but is receiving services including the bilateral knee splint application. During a review of the facility-provided CMS Resident Assessment Instrument Version 1.20.1 Manual, dated 10/2025, the manual indicated section O0500,Review for each activity throughout the 24-hour period. Enter 0, if none. Technique – Activities provided by restorative nursing staff. Splint or Brace Assistance Code provision of (1) verbal and physical guidance and direction that teaches the resident how to apply, manipulate, and care for a brace or splint; or (2) a scheduled program of applying and removing a splint or brace. These sessions are individualized to the resident's needs, planned, monitored, evaluated, and documented in the resident's medical record. b. During a review of Resident 31's FS, the FS indicated Resident 31 was admitted in the facility on 4/17/2026 with diagnoses including alcohol use, generalized muscle weakness, and lack of coordination. During a review of Resident 31's H&P, dated 4/20/2026, the H&P indicated Resident 31 had the capacity to understand and make decisions. During a review of Resident 31's most recent MDS admission assessment, dated 2/21/2026, the MDS assessment indicated that the resident was taking antibiotic with an indication for use. During a review of Resident 31's Order Summary Report, dated 4/30/2026, the Order Summary Report did not indicate that Resident 31 had a physician's order for antibiotic. During a concurrent interview and record review on 5/7/2026 at 8:35 a.m. with the MDSC, Resident 31's Order Summary Report, discontinued or completed physician's order, and acute hospital records were reviewed. The MDSC stated the Order Summary Report, discontinued or completed physician's orders, and acute hospital records did not indicate that Resident 31 received an antibiotic during hospitalization and while in the facility. The MDSC stated it was a coding error. The MDSC stated the MDS assessments are supposed to be coded accurately as the MDS assessment was the clinical picture of the resident. The MDSC stated she should have coded the MDS assessment accurately as the MDS is the clinical picture of the resident in order to properly care for Resident 31 and prevent delay in providing the care needed. During an interview on 5/7/2026 at 11:05 a.m. with the ADON, the ADON stated that the MDS nurses check the resident's chart for accuracy and assess the residents to ensure that the resident's needs will be addressed appropriately to prevent delay in providing the care they need. The ADON stated that the MDSC are supposed to accurately code the MDS assessments as it presents the clinical picture of the residents for all members of the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) and the type or types of care the resident is receiving in the facility. The ADON stated if the electronic health record (EHR) or acute hospital records did not indicate that Resident 31 received antibiotic, it should not have been coded in the MDS assessment. During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, last reviewed and approved on 1/2026, the P&P indicated that any person completing a portion of the MDS must sign and certify the accuracy of that portion of the assessment. The P&P indicated that The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment. The resident assessment coordinator is (continued on next page)

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the resident assessment coordinator, who is a registered nurse. During a review of the facility's P&P titled, Resident Assessment Instrument, last reviewed on 1/2026, the P&P indicated: - The purpose of the assessment is to describe the resident's capability to perform daily life functions and to identify significant impairments in functional capacity. - Information derived from the comprehensive assessment helps the staff to plan care that allows the resident to reach his/her highest practicable level of functioning. - All persons who have completed any portion of the MDS resident assessment form must sign such document attesting to the accuracy of such information.