

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER View Park Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Don Felipe Drive Los Angeles, CA 90008	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: Kitchen and storage areas were not free from dirt and food debris. Reach-in refrigerator 2's bottom shelves contained dirt and dust debris. Reach-in refrigerator 1's vent, shelves, walls, roof and pipe had white spots, dirt and dust accumulation. Reach-in freezer 4 had dirt and food debris on the bottom shelves. Dry storage racks had dust buildup. A fan contained dust by the dishwashing machine was blowing air to the silverwares. Six (6) of 6 carts had old sticker residues. Drying racks had food and dirt debris. Disposable spoon drawer had dirt debris. Tray-line (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) roof had dried up food spills. Kitchen equipment and surfaces are not of cleanable surface. Reach-in refrigerator 2's shelves had chips, cracks and amber discoloration. Reach-in refrigerator 1's shelves had chips, cracks and amber discoloration. Five (5) of 5 dented cans (a packaged metal food containers that have been physically deformed or crushed) were found with non-dented cans. There was cross-contamination during food preparation. Cook 1 used the Robo coupe (a brand of food processor) for bread when there are still water particles after washing. Dietary Aide 1 (DA 1) did not wash the knife after using it for peanut butter, instead rinsed it with water then dipped the knife in the jelly. Water from the thawing raw chicken was contaminating the white chopping board used for bread and dairy products. Dietary Aide 2 (DA 2) wiped the wet plates using a yellow towel. Onions were touching the grey trash can. Cook 1 did not wash her hands after touching the lid of the trash can and before touching the pan of puree food and milk. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 84 of 84 medically compromised residents who received food and ice from the kitchen. Findings: 1. a. During an initial kitchen tour observation on 6/29/2026 at 8:12a.m., of the Reach-in refrigerator 2, observed dirt debris on the bottom shelves. During an interview on 6/29/2026 at 8:29 a.m., with the Dietary Supervisor (DS), the DS stated they (kitchen staff) clean Reach-in refrigerator 2 every day after the shift and it was cleaned last night. The DS stated the maintenance cleaned the vent a month ago and his expectation is for the shelves to be clean with no food spillage, but the bottom shelves contained dust particles. The DS stated it was important to clean the refrigerators to prevent cross-contamination resulting in foodborne illnesses for the residents. b. During an initial kitchen tour observation on 6/29/2026 at 8:18 a.m., of the Reach-in refrigerator 1, observed the vent, bottom shelves and tube had white spots, dirty debris and white residues. During an interview on 6/29/2026 at 8:44 a.m., with the DS, the DS stated Reach-in refrigerator 1 was cleaned last night but it has dirt and dust buildup and if it was cleaned last night there should not have dust and dirt accumulation. c. (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly when: Two (2) of 2 grey trash cans were not completely covered whennot actively in use during lunch service. One (1) of 2 dumpster's (a movable waste container designedto be brought and taken away by special collection vehicles, or to a bin that specially designed garbage truck lifts) cover was not tight fitting and it had space in between the closure. These failures had the potential to attract pests such as rats, cockroaches, flies, and ants, which may spread diseases to 84 of 84 residents living in the facility. Findings: 1. During an observation on 6/29/2026 at 11:06 a.m., of the grey trash can, observed the grey trash can not completely closed. During an observation on 6/29/2026 at 11:53 a.m., of the grey trash can, observed the grey trash can not covered while not being used. During an observation on 6/29/2026 at 12:06 a.m., of the grey trash can by the preparation area, observed they grey trash can not covered while not actively being used. During an observation on 6/29/2026 at 12:27 p.m., of the grey trash can by the preparation area, observed the grey trash can not covered while not actively being used. During an interview on 6/29/2026 at 12:33 p.m., with the Dietary Supervisor (DS), the DS stated the trash can has to be always closed because it attracts bugs and pest and to prevent cross contamination. 1. During a concurrent observation and interview on 6/30/2026 at 10:31 a.m., of the dumpsters with the DS outside the facility, observed the dumpster cover had space and flies were flying around it. The DS stated the lid of the dumpster was not tight fitting that is why it had space and it was loose. The DS stated the dumpster needed to be closed properly to avoid attracting pests that could possibly spread diseases to the residents. During a review of the facility's policy and procedure (P&P) titled, Waste Control, dated 3/20/2026, the P&P indicated 2. Trash bins should be covered at all times. 6. Outside garbage bin should be kept closed at all times and surrounding area must e clean. During a review of Food Code 2022, indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility did not meet standards of quality when licensed staff failed to follow or clarify physician medication orders for two five residents (Residents 4, 63, and 44) by failing to: A. For Resident 4, facility licensed nurse did not dilute potassium chloride (used to treat low blood potassium) prior to administration via gastrostomy tube (G-tube, care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine) in accordance with manufacturer's specification and physician's order. B. Facility failed to ensure the correct medication dose of ferrous sulfate (used to treat anemia caused by low amounts of iron in the blood) was available and administered to Resident 4 between 4/2026 - 6/2026 as ordered. C. For Resident 63, facility licensed nurse did not check heart rate (HR, the number of times the heart beats per minute) prior to administration of metoprolol (used to treat high blood pressure, chest pain, and heart failure) 50 mg as ordered. D. For Resident 63, facility licensed nurse did not check respiration rate (RR, the number of breaths taken per minute [bpm]) or ensure the pain level was within the ordered parameter prior to administration of tramadol (a controlled medication [or controlled substance, regulated by the government because it carries a risk of misuse, addiction, or physical dependence] used to manage moderate to severe pain) 50 mg as ordered. E. For Resident 44, facility licensed nurse did not check HR prior to administration of metoprolol 50 mg as ordered. These failures had the potential to result in ineffective pain and/ or blood pressure management of Resident 63 and Resident 44, and increased Resident 4's risk of gastrointestinal conditions with the administration of undiluted potassium chloride via G-tube. These failures placed Resident 4, Resident 44, and Resident 63 at risk for uncontrolled symptoms, weakness, deterioration in condition, and the need for additional medical interventions. Findings: A. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses including Attention to Gastrostomy (G-tube), Ileus (a condition where the intestines do not move food and waste normally, causing blockage and discomfort), Hypokalemia (low levels of potassium in the blood, which can lead to weakness, tiredness, or cramps), hypertension (high blood pressure), Anemia (used to treat anemia caused by low amounts of iron in the blood), Gastro-esophageal Reflux disease (GERD, a condition where stomach acid frequently flows back into the tube connecting the mouth and stomach, causing heartburn and irritation), and Dementia (a progressive brain disease that affects memory, thinking, and behavior). During a review of Resident 4's history and physical (H&P) dated 3/31/2026, the H&P indicated Resident 4 does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 4 was rarely or never understood or able to understand. The MDS indicated Resident 4 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a medication administration (pass) observation on 7/1/2026 between 8:22 AM to 8:51 AM, with Licensed Vocational Nurse (LVN) 3 on Station A, at Medcart A, LVN 3 prepared the following medications for Resident 4: 1. spironolactone (a potassium-sparing diuretic [water pill]) 50 milligram (mg, unit of measurement by weight) oral tablet, one tablet 2. lisinopril (treat high blood pressure) 5 mg oral tablet, one tablet 3. LiqueCel (protein supplement) 16 gram (gm, unit of measurement by weight) Protein 4. Docusate sodium (stool softener) 100 mg oral tablet, one tablet 5. Nitrofurantoin (antibiotic) 100 mg oral capsule, one capsule 6. Tamsulosin (treat benign prostatic (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration (pass) observation and interview on 6/30/2026 between 9:39 AM to 10:20 AM, with LVN 1, LVN 1 prepared Resident 63's medications that included but was not limited to metoprolol 50 mg and tramadol 50 mg. LVN 1 entered Resident 63's room, checked the resident's blood pressure and stated the blood pressure was 134/68 mmHg. LVN 1 was not observed checking Resident 63's HR (also called pulse rate) or RR prior to administering to the resident metoprolol and tramadol to the resident. During an interview on 6/30/2026 at 10:18 AM with LVN 1, LVN 1 stated that Resident 63's HR should have been checked prior to administering the blood pressure medication, metoprolol. LVN 1 stated it was important to check both the blood pressure and heart rate to prevent Resident 63 from becoming hypotensive or experiencing any cardiac or medical issues. D. During a concurrent interview and record review on 6/30/2026 at 2:44 PM with LVN 1, Resident 63's OSR, MAR, and Progress Notes for the month of June 2026, were reviewed for the use of tramadol. LVN 1 stated, for Resident 63, the physician ordered tramadol to be administered twice a day for severe pain of 7 to 10 on a pain scale of 10 being very severe pain, and to hold for drowsiness, or RR less than 12, and to document the pain site in the progress notes. LVN 1 stated that Resident 63's RR was not checked prior to the administration of tramadol as ordered and the pain level was documented in the MAR as zero (0) on 6/30/2026 for the scheduled 9 AM administration of tramadol, which was outside of the physician's ordered parameter to administer. During a review of the facility's pain scale of 0 to 10 indicated a pain assessment level of: 0 = no pain 1 - 3 = mild pain 4 - 6 = moderate pain 7 - 9 = severe pain, and 10 = very severe pain. During a concurrent interview and record review on 6/30/2026 at 2:58 PM with a Registered Nurse (RNS) 1, Resident 63's OSR and prescription label for tramadol was reviewed. Resident 63's prescription label for tramadol indicated to administer tramadol 50 mg every 12 hours (routine) for moderate pain, with a fill date of 6/2/2026. RNS 1 stated there was no documentation that the pharmacy or the physician was called when there was discrepancy between the physician's order and the prescription label. During a concurrent telephone interview and record review on 6/30/2026 at 3:27 PM, in the presence of the DON, the facility's dispensing pharmacist (Pharm) 2 was called and Resident 63's physician order and prescription label for tramadol 50 mg was reviewed. Pharm 1 reviewed the initial order sent from the facility to the pharmacy and stated on 3/17/2026 which included the physician's parameters hold tramadol if Resident 63 was drowsy, or RR was less than 12, and to give for pain level of 7 to 10. Pharm 2 stated the pharmacy should have included the physician hold parameters on Resident 63's tramadol prescription label. Pharm 2 stated the rationale for holding tramadol if drowsy or RR is less than 12 is because tramadol can slow the resident's breathing and cause respiratory depression and it is crucial to include the parameters on the prescription label. E. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure). During a review of Resident 44's history and physical (H&P) dated 5/17/2026, the H&P indicated Resident 44 has the capacity for medical decision making. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 44 has the ability to understand and be understood. The MDS indicated Resident 44 was dependent (helper provides all effort) for toileting, required substantial assistance (Helper provides more than half the effort) for bathing and personal hygiene and required setup for eating and oral hygiene. During a review of Resident 44's OSR dated 6/30/2026, the OSR indicated physician's order for metoprolol tartrate 50 mg, one tablet by mouth two times a day for hypertension. Hold for SBP less than 100 mmHg or HR less than 60. Give with food, order dated 6/13/2026. During a concurrent medication administration (pass) observation and interview on 6/30/2026 between 8:40 AM to 8:53 AM, with LVN 2, LVN 2 prepared Resident 44's medications that included but was not (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	limited to metoprolol 50 mg. LVN 2 entered Resident 44's room, checked the resident's blood pressure and stated the blood pressure was 126/74 mmHg. LVN 2 was not observed checking Resident 44's HR. Resident 44 took all medications by mouth. During an interview on 6/30/2026 at 10:31 AM, with LVN 2, LVN 2 stated that Resident 44's HR was not checked prior to administering metoprolol during morning medication pass on 6/30/2026, and the resident's HR should have been checked. LVN 2 stated the physician's order had a parameter to hold the blood pressure medication, metoprolol for HR less than 60 bpm. LVN 2 stated if the HR was to go too low, could cause Resident 44 to experience an adverse reaction. During an interview on 7/2/2026 at 2:18 PM, with DON, DON stated if resident (Resident 44) was given metoprolol with a low HR, the medication could cause the resident's HR to drop further and lead to bradypnea. DON stated residents' vital sign (a measurement of basic body functions, such as blood pressure, heart rate, temperature, and breathing rate, used to assess a person's health) should be taken before administering medications with an ordered parameter which is used to determine whether to give or not give a medication. During a review of the facility's policy and procedure (P&P) titled Administering Medications revised 3/2023, the P&P indicated .4. Medications are administered in accordance with prescribers orders, including any required time frame.6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.8. If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or facility's medical director to discuss the concerns.10. The following information is checked/ verified for each resident prior to administering medications. vital signs, if necessary. During a review of the facility's P&P titled, Enteral Tube Medication Administration, dated 8/2014, the P&P indicated, Medications that are GI irritants (such as potassium chloride solution) are diluted as recommended for oral administration, since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes. During a review of the facility's P&P titled, Ordering and Receiving Medications From the Dispensing Pharmacy, dated 1/2022, the P&P indicated, Receiving Medications from the Pharmacy.1. A licensed nurse.b. Verifies medications received and directions for use with the medication order form and/ or physician's orders. c. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. During a review of the facility's P&P titled Provider Pharmacy Requirements, dated 1/2025, the P&P indicated, The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to. Accurately dispensing prescriptions based on authorized prescriber orders. Providing medications packaged in accordance with the facility's needs.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for one of one sampled resident (Resident 9), the facility failed to:1.Notify a physician that Resident 9 had an indwelling catheter (a thin flexible tube that drains urine from the bladder {organ that holds the urine before voiding}) from 7/2023 to .7/2026 to obtain a urologist consult2.Ensure Resident 9 received bladder and bowel (B&B) training program (a program of toileting schedule to try to restore or overcome urinary and bowel incontinence) while resident had the indwelling catheter according to Resident 9's B&B assessment dated [DATE].These deficient practices potentially resulted in Resident 9 developing Urinary Tract infection (UTI - infection in any part of the urinary system in body), serious complications including sepsis (a potentially life-threatening complication of an infection) on 9/3/2025 and 11/8/2025 which resulted in Resident 9 being transferred to a general acute care hospital (GACH) where the resident was diagnosed with UTI, sepsis and was treated with antibiotics (medications to treat infection).Findings: During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted Resident 9 on 7/2/2023 and readmitted on [DATE] with diagnoses that included cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or partial paralysis on one side of the body) and Benign Prostate Hyperplasia (BPH - enlarged prostate gland which leads to squeezing/narrowing of the urethra {A muscular tube that allows urine to pass out of bladder and exit the body}). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool) dated 3/20/2026, the MDS indicated Resident 9 had moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 9 used wheelchair. The MDS indicated Resident 9 needed supervision/touching assistance with eating, moderate assistance with oral hygiene and maximum assistance with activities of daily living (ADL- sitting/laying, toileting hygiene, shower/bath, upper, personal hygiene and toilet transfer). During a review of Resident 9's History and Physical (H&P - medical document which include resident's background, physical exam and assessment) dated 11/14/2025, the H&P indicated Resident 9 can make needs known but cannot make medical decisions. During a review of Resident 9's Order Summary dated 7/2/2026 at 2:13 pm, the order summary indicated indwelling catheter care every shift, monitor indwelling catheter urinary drainage bag and document: color, consistency, odor, hematuria, bladder distention, burning sensation/signs of UTI (+ = presence of UTI. (0) - absence of UTI). During the review of Resident 9's Change of Condition (COC - a document that is completed for any sudden change in condition of a resident) dated 9/3/2025, the COC indicated Resident 9 had fever of 101.7 degrees Fahrenheit (F - unit to measure temperature, normal temperature range - 97 degrees F - 99 degrees F) and blood-tinged urine. Resident was transferred to GACH on the same day (9/3/2025) per physician orders. During the review of Resident 9's GACH Physician Progress Notes dated 9/8/2025 at 10:22 am, indicated Resident 9's had diagnosis of severe sepsis secondary to UTI. Resident 9 received Aztreonam 1000mg Intravenous (medication injecting directly into vein, entering blood immediately and medication start working right away) twice a day. During the review of Resident 9's COC dated 11/8/2025, COC indicated the urine in Resident 9's indwelling catheter was red and the resident complaint of penile (penis - male genital/private part which carries urine outside of the body) pain level of eight out of 10 (8/10 - numerical pain assessment tool where zero is no pain and 10 is severe pain). The COC indicated Resident 9 said that this (pain and red color in the urine) has happened to (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	him in the past and wishes to go to the hospital. The COC indicated Resident 9 was transferred to a GACH on 11/8/2025 for further evaluation and management per physician orders. During the review of Resident 9's GACH Infection Disease Physician Progress notes dated 11/12/2025 at 12:56 pm, indicated Resident 9's UA was positive for UTI. Resident 9 had sepsis during hospitalization due to complicated UTI (difficult to treat UTI). ID progress notes indicated Resident 9's urine culture and sensitivity (C & S - urine test that takes 24 - 48 hours to grow bacteria in laboratory that caused UTI in resident, so antibiotics can be prescribed to target/treat that specific bacteria) was positive for Escherichia coli (E.coli- bacteria found in human gut and feces) Resident 9 received Macrobid (medication to treat infection) 100 mg every 12 hours by mouth daily for UTI and sepsis during the hospitalization. During the review of Resident 9's GACH Emergency physician documentation dated 11/8/2025 at 10:42 pm, resident's indwelling catheter was changed in emergency department on 11/8/2026. During the review of Resident 9's B&B assessment dated [DATE], (B&B assessment score is a clinical evaluation used to identify underlying issues related to urinary and fecal continence, retention, or dysfunction) was 8 (score of 0-15 indicates the resident is a candidate for B&B training). During an interview and concurrent record review on 7/1/2026 at 2:30 pm with Director of Nursing (DON), Resident 9's medical chart was reviewed. DON stated that the facility did not have documented evidence that Resident 9 was admitted with an indwelling catheter. DON stated that the facility did not have Resident 9's admission records, H&Ps and admission orders from 7/2/2023 and resident was readmitted on [DATE] and 11/14/2025. DON stated, Per facility's B&B policy any resident with B&B assessment score of 0-15 must receive B&B training or reason for not attempting B&B training should be documented. (Resident 9) was not seen by urologist[AD1.1] (physician specialized in diagnosing and treating diseases of urinary tract) during these three years (7/2023-7/2026), but he has an appointment (8/4/2026) with the urologist now. During an interview on 7/1/2026 at 3:10 pm with Infection Preventionist (IP), IP stated that if a resident has a chronic (long term) indwelling catheter and the indwelling catheter is not changed regularly per doctor's orders (there were no doctor's orders), the resident risks getting UTI, bladder infection and even sepsis. IP stated I'm not sure if (Resident 9) was seen by urologist in the three years the resident has been in the facility. During a telephone interview on 7/1/2026 at 3:28 pm with Resident 9's Nurse Practitioner (NP), NP stated Resident 9 has a chronic indwelling catheter for BPH. NP stated that if Resident 9 is not assessed for B&B training, the resident can develop UTI, bladder infection, bladder spasm, hematuria (blood in urine) and a lot of other complications (did not specify. During a telephone interview on 7/1/2026 at 4:29 pm with Medical Director (MD), MD stated Resident 9 needs an indwelling catheter due to the resident's diagnosis, of BPH and obstructive and reflux uropathy (medical condition that affect the urinary tract, causing urine to back up and potentially damage the kidneys) and the residents need to be seen by a urologist. MD stated that any time a patient/resident has an indwelling catheter, the indwelling catheter can be a source of infection. MD stated, For my patients, I try that for (indwelling) catheter foley to be changed every one to three months. MD stated that usually, patients/residents are seen by outpatient urologists when they are in the facility. Resident 9's doctor should have placed an order for urology consult sooner the facility staff should have alerted Resident 9's physician regarding Resident 9's long term. indwelling catheter and the facility should have documented everything regarding the indwelling care.During a review of the facility's policy and procedures (P&P) titled, Bowel and Bladder Assessment dated 3/20/2026, the P&P indicated, Bowel and bladder assessment will be completed within 14 days after admission and updated quarterly. Based on the score, 0-15 Indicates that the resident is a candidate for B&B training. During a review of the facility's policy and procedures (P&P) titled, Notification of Physician dated (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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NAME OF PROVIDER OR SUPPLIER View Park Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Don Felipe Drive Los Angeles, CA 90008	
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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/20/2026, the P&P indicated, When there is a change of condition, the attending physician or designate/alternate will be notified promptly. If the attending physician or alternate physician is not available, a physician on the UR panel will be contacted for orders.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement gastrostomy tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) orders, in accordance with physician orders and facility policy and procedures (P&P) titled, Enteral Tube Medication Administration, for three of three sampled residents (Resident 4, Resident 63, Resident 32) administered medications via G-tube by failing to ensure: (Cross Reference F726, F759 and F760) A. Resident 32's G-tube was flushed with prescribed amount of water after medication administration B. Resident 63 G-tube was flushed with prescribed amount of water before, after, and during medication administration C. Resident 4 was administered medication via G-tube by gravity (utilizing the natural downward pull of gravity to deliver the medication into the stomach through the G-tube/feeding tube) and with sufficient fluids in accordance with manufacturer's specification and physician orders This deficient practices had the potential to increase the risk of medication errors, which could result in Resident 4, Resident 32, and Resident 63's G-tube becoming clogged (blocked), dislodged, causing pain, discomfort, harm, delay in care or hospitalization of residents. Findings: A. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including Attention to Gastrostomy (care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine), polyneuropathy (nerve damage affecting multiple nerves, often causing weakness, numbness, or pain), osteoarthritis (a joint disease causing pain and stiffness), right ankle and foot During a review of Resident 32's history and physical (H&P) dated 11/7/2027, the H&P indicated Resident 32 does not have the capacity to understand and make decisions During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 10/10/2025, the MDS indicated Resident 32 was severely cognitively (has serious difficulty with thinking, memory, or understanding) impaired. The MDS indicated Resident 32 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a review of Resident 32's Order Summary Report (OSR) with active orders as of 7/1/2026 included physician's orders for: 1. Enteral Feed Order every shift (Enteral/G-tube) flush with 10 milliliters (ml, unit of measurement by volume) of water between medication administration, order date 4/26/2025 2. Enteral Feed Order every shift (Enteral/G-tube) may give 30 ml of fluids via G-tube pre and post medication administration, order date 10/31/2021 3. EBP Enhanced Barrier Precautions for G-tube, order date 3/4/2025 4. FYI Flush with 10 ml of water between medications/supplement administration every shift, order date 3/30/2025 5. Cranberry Oral Tablet 450 mg, give one tablet via G-tube one time a day for prophylactic/ urinary tract infection, order date 9/28/2024 6. Docusate Sodium Tablet 100 mg, give one tablet via G-tube one time a day for bowel management, hold for loose bowel movements, order date 1/1/2024 During a medication pass observation, on 6/30/2026 between 8:18 AM to 8:36 AM, with LVN 2, on Station B, Medication Cart C, LVN 2 was observed preparing the following medications for Resident 32: 1. Cranberry 450 mg, one tablet 2. Docusate sodium 100 mg, one tablet During a concurrent medication pass observation and interview, on 6/30/2026 between 8:18 AM to 8:36 AM, with LVN 2 for Resident 32, at Station B, Medication Cart C, the following occurred: On 6/30/2026 at 8:28 AM, LVN 2 stated she had prepared a total of two morning medications for Resident 32. LVN 2 crushed each tablet individually and placed (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	them into separate medication cups and stated that she added 30 ml of water to each cup. On 6/30/2026 at 8:30 AM, LVN 2 entered Resident 32's room without putting on a gown. LVN 2 turned off Resident 32's G-tube and stated she flushed the G-tube with 30 ml of water. On 6/30/2026 at 8:31 AM, LVN 2 administered to Resident 32 the crushed docusate sodium in water, with undissolved medication observed remaining in the medication cup. On 6/30/2026 at 8:32 AM, LVN 2 administered to Resident 32 the crushed cranberry tablet in water, with undissolved medication observed remaining in the medication cup. LVN 2 stacked the two medications cups. On 6/30/2026 at 8:33 AM, LVN 2 stated that she gave a final flush of 30 ml of water to Resident 32. On 6/30/2026 at 8:34 AM, LVN 2 was asked to unstack the medication cups. LVN 2 unstacked Resident 32's medication cups and added 10 ml of water to each medication cup, and administered the medications to Resident 32. LVN 2 stated there was no need for a final flush because she already gave 30 ml of water to Resident 32. During an interview on 6/30/2026 at 9:03 AM, with LVN 2, LVN 2 stated that the purpose of the final flush via G-tube was to make sure all the medication goes into the resident's stomach. LVN 2 stated that she did not do a final flush after administering the remaining medications that was observed inside of the medication cups and that she should have to make sure all of Resident 32's medication went into the stomach to be absorbed. During an interview on 6/30/2026 at 3:43 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that she could not recall the last time she was observed performing a return demonstration (a process where staff show their ability to correctly perform a procedure by demonstrating it in front of an evaluator) for G-tube medication administration to residents. B. During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Attention to Gastrostomy (care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine), Dementia (a progressive brain disease that affects memory, thinking, and behavior), Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar), Hypertension (HTN, high blood pressure), and Long Term (Current) use of Opiate Analgesic (a controlled medication used to relieve pain). During a review of Resident 63's history and physical (H&P) dated 12/20/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 63 was severely cognitively impaired. The MDS indicated Resident 63 was dependent (helper provides all of the effort) for all aspects of activities of daily living (ADLs, routine tasks/activities such as eating, oral and personal hygiene, toileting, bathing, dressing, and transfer, tasks a person performs daily to care for themselves). During a review of Resident 63's OSR dated 6/30/2026, the OSR included physician's orders for: 1. Enteral Feed Order every shift (Enteral/G-tube) flush with 10 milliliters (ml, unit of measurement by volume) of water between medication administration, order date 12/24/2023 2. Enteral Feed Order every shift (Enteral/G-tube) may give 30 ml of fluids via G-tube pre and post medication administration, order date 12/24/2023 3. Enhanced Barrier Precautions (EBP, an infection control strategy used in nursing homes and long-term care facilities to prevent the spread of multidrug-resistant organisms (MDROs)) for G-tube, order date 4/22/2026 4. FYI Flush with 10 ml of water between medications/supplement administration every shift, order date 3/30/2025 5. Aspirin 81 MG Chewable Tablet, give one tablet via G-tube one time a day for cerebrovascular accidents (CVA or stroke), preventative care (PPX), order date 12/24/2023 6. Metoprolol Tartrate 50 mg, give one tablet via G-tube one time a day for hypertension (Blood pressure above the reference range 120/80 millimeters of mercury [mmHg] a unit of measure of pressure] - 130/80 mmHg) hold for Systolic ([SBP] - the pressure caused by heart while contracting) of less than 110 mmHg or HR (HR, reference range for a normal adult heart rate is (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	typically 60-100 bpm, with values below 60 bpm considered bradycardia [slow heart rate]) less than 60 bpm, give with food, order dated 10/26/2024. 7. Lisinopril 20 MG, give one tablet via G-tube one time a day for HTN, hold for SBP less than 110 mmHg, order date 2/17/2026. 8. Clopidogrel (used to prevent blood clots) Oral Tablet 75 mg, give one tablet via G-tube one time a day for cerebrovascular accidents (CVA or stroke), preventative care (PPX), order date 12/24/2023. 9. Tramadol 50 mg, give one tablet via G-tube twice a day for severe pain (7-10). Hold if drowsy or RR (reference range 12-20 breaths per minute [bpm]), with values below 12 bpm considered bradypnea (abnormally slow breathing) less than 12 bpm. Document pain site in the Progress Notes, order dated 3/17/2026 During a review of Resident 32's Care Plan (CP) included the following interventions: a. Resident 63 was at risk for cardiac distress related to hypertension. pacemaker status. At risk for irregular pulse, elevated blood pressure (BP). hypotension (low blood pressure). revised on 6/29/2026. Resident 63's Care Plan indicated, resident will have no unrecognized signs and symptoms of cardiac distress daily. Give medication as ordered. Monitor pulse rate and blood pressure as ordered b. Resident 63 was at risk for adverse effects from Black Box Medication [Tramadol], revised on 6/2/2026. Resident 63's Care Plan indicated resident's risk for the use of Black Box medication (s) will be monitored/identified by licensed nurse. MD will be notified promptly. Risk of opioid addiction, abuse and misuse, which can lead to overdose and death. Serious life threatening, or fatal respiratory depression may occur with use. Monitor for respiratory depression. may result in profound sedation, respiratory depression, coma and death During a medication pass observation, on 6/30/2026 between 9:35 AM to 10:13 AM, with LVN 1, at Station A, Medication Cart 1, LVN 1 was observed preparing the following medications for Resident 63: 1. Aspirin 81 MG Chewable Tablet, one tablet 2. Lisinopril 20 MG, one tablet 3. Metoprolol tartrate 50 MG, one tablet 4. Clopidogrel 75 MG, one tablet 5. Tramadol hydrochloride 25 MG, one tablet During a concurrent medication pass observation and interview, on 6/30/2026 between 9:35 AM to 10:13 AM, with LVN 1 for Resident 63, at Station A, Medication Cart 1, the following occurred: On 6/30/2026 at 10:02 AM, LVN 1 stated she had prepared a total of five medications for Resident 63. LVN 1 crushed each medication individually and placed them into separate medication cups and stated that she added 30 ml of water to each medication cup. On 6/30/2026 at 10:05 AM, LVN 1 entered Resident 63's room without putting on a gown. LVN 1 put on gloves without washing or sanitizing her hands, checked Resident 63's G-tube placement. On 6/30/2026 at 10:06 AM, LVN 1 filled the syringe to the top with water and stated that she provided an initial flush of 60 ml of water to Resident 63 via G-tube. LVN 1 administered each medication, one at a time, flushing with 30 ml to 40 ml of water between each medication. LVN 1 provided Resident 63 with a final 30 ml of water G-tube flush. On 6/30/2026 at 10:12 AM, Resident 63 cough, pushing 50 ml of fluid back up into the syringe. LVN 1 asked Resident 63 to relax to allow the fluids to down through the G-tube. LVN 1 stated to Resident 63, I know I gave a lot of water. During an interview on 6/30/2026 at 10:21 AM, with LVN 1, LVN 1 stated she gave the following amounts of water to Resident 63 during G-tube medication administration: a. An initial flush of 60 ml of water b. A final flush of 30 ml of water c. Dissolved five crushed medications each in 30 ml of water d. Added an additional 15 ml to 30 ml of water to make sure the resident received all of the medication from the medication cup e. Flushed in between each medication with 30 ml of water for a total of four times (for an overall total of about 450 ml of water during G-tube medication administration) LVN 1 stated that she wanted to make sure that Resident 63's G-tube did not clog up and that is why she gives plenty of fluid through the G-tube during medication administration. During an interview on 6/30/2026 at 3:08 PM with LVN 1, LVN 1 acknowledged not wearing a gown when she administered medications to Resident 63 via G-tube and stated that she should have. C. During a review of Resident 4's admission Record, the admission (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record indicated Resident 4 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses including Attention to Gastrostomy (G-tube), Ileus (a condition where the intestines do not move food and waste normally, causing blockage and discomfort), Hypokalemia (low levels of potassium in the blood, which can lead to weakness, tiredness, or cramps), hypertension (high blood pressure), Anemia (used to treat anemia caused by low amounts of iron in the blood), Gastro-esophageal Reflux disease (GERD, a condition where stomach acid frequently flows back into the tube connecting the mouth and stomach, causing heartburn and irritation), and Dementia (a progressive brain disease that affects memory, thinking, and behavior). During a review of Resident 4's H&P dated 3/31/2026, the H&P indicated Resident 4 does not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated Resident 4 was rarely or never understood or able to understand. The MDS indicated Resident 4 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a review of Resident 4's OSR dated 7/1/2026, the OSR included physician's orders for: 1. Enteral Feed Order may give 30 ml of fluids via G-tube pre and post medication administration, order date 3/30/2026. 2. Enteral Feed Order as needed (Enteral) may slow push medications and fluids via G-tube as needed (PRN) if not contraindicated, order date 3/30/2026. 3. Enteral Feed Order every shift (Enteral) flush 10 ml of water between medication administration, order date 3/30/2026. 4. Enhanced Barrier Precautions (EBP) for G-tube and wounds, order date 3/31/2026. 5. Potassium chloride oral solution 20 mEq/15 ml (10 %), to give 30 ml via G-tube one time a day for hypokalemia (low blood potassium). Give 40 mEq = 30 ml, dilute with 4 (four) ounces (oz, unit of measurement by volume) of water prior to administering, order date 4/5/2026. 6. Spironolactone (a potassium-sparing diuretic [water pill]) 50 milligram (mg, unit of measurement by weight), give one tablet via G-tube two times a day for HTN. Hold for SBP less than 100 mmHg. Handle pills with gloves, order date 5/17/2026. 7. Tamsulosin 0.4 mg, give one capsule via G-tube one time a day for avoiding dysfunction. Give after breakfast, order date 3/30/2026. 8. Lisinopril (treat high blood pressure) 5 mg, give 5 mg via G-tube two times a day for HTN. Hold for SBP less than 110 mmHg, order date 3/30/2026. 9. LiquaCel (protein and amino acids supplement) Oral Liquid, five 30 ml via G-tube two times a day for wound healing until 8/1/2026, order date 6/16/2026. 10. Docusate sodium (stool softener) 100 mg, give one tablet via G-tube two times a day for stool softener/bowel management. Hold for loose bowel movements, order date 4/5/2026. 11. Nitrofurantoin (antibiotic) 100 mg oral capsule, give 100 mg via G-tube every 12 hours for urinary tract infection (UTI) for four (4) days, order date 6/29/2026. 12. Ferrous Sulfate Oral Solution 300 mg/ 5ml, give 5 ml via G-tube one time a day for anemia, order date 4/5/2026. During a review of Resident 4's Care Plans indicated: a. Resident 4 is on G-tube feeding, and at risk for aspiration, nausea and vomiting, abdominal distention, diarrhea, constipation. revised 5/3/2026. Resident 4's care plan indicated, flush G-tube with water as ordered. b. Resident 4 is at risk for GI distress or bleeding secondary to GERD, revised 4/8/2026. Resident 4's care plan indicated, assess for signs and symptoms of GI distress, such as nausea and vomiting, abdominal pain, abdominal distention, reflux, bleeding. and notify MD. Administer medication as ordered. c. Resident 4 is at risk for serum potassium variation, revised 4/8/2026. Resident 4's care plan indicated to administer medications as ordered. d. Resident 4 is at risk for possible side effects or adverse reactions related to antibiotic therapy, Macrochantin (Nitrofurantoin) Oral Capsule 100 mg, revised 6/30/2026. Resident 4's care plan indicated, administer antibiotic therapy as ordered for UTI. Notify MD if infection does not appear to be improving. maintain adequate hydration every shift per assessed needs. During a medication administration (pass) observation on 7/1/2026 between 8:22 AM (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to 8:51 AM, with Licensed Vocational Nurse (LVN) 3 on Station A, at Medcart A, LVN 3 prepared the following medications for Resident 4:1. Spironolactone (a potassium-sparing diuretic [water pill]) 50 milligram (mg, unit of measurement by weight) oral tablet, one tablet2. Lisinopril (treat high blood pressure) 5 mg oral tablet, one tablet3. LiguaCel (protein supplement) 16 gram (gm, unit of measurement by weight) Protein4. Docusate sodium (stool softener) 100 mg oral tablet, one tablet5. Nitrofurantoin (antibiotic) 100 mg oral capsule, one capsule6. Tamsulosin (treat benign prostatic hyperplasia [BPH] enlarged prostate that can cause difficulty urinating, painful urination or increased urinary frequency or urgency) 0.4 mg oral capsule, one capsule7. Potassium chloride oral solution 10 percent (%) 20 milliequivalents (mEq, unit of measurement) per 15 milliliters (ml, unit of measurement by volume), 30 ml (40 mEq) During a concurrent medication pass observation and interview, on 7/1/2026 between 8:54 AM to 9:17 AM, LVN 3 for Resident 4, at Station A, Medcart A, the following occurred:On 7/1/2026 at 8:51 AM, LVN 3 put on gloves, crushed the crushable tablets and placed them into individual medication cups and opened the capsules of Nitrofurantoin and Tamsulosin and poured the contents of the capsules into individual medication cups.On 7/1/2026 at 8:54 AM, LVN 3 put on a gown, changed gloves without washing or sanitizing her hands and entered Resident 4's roomOn 7/1/2026 at 9:01 AM LVN 3 stated she checked Resident 4's G-tube placement and checked for residual. LVN 3 mixed 5 ml to 10 ml of water to each medication cup containing the contents of the tablets and capsules. LVN 3 administered each medication individually via G-tube followed by 5 ml to 10 ml water flushOn 7/1/2026 at 9:12 AM, LVN 3 used the syringe to draw up the dissolved tamsulosin and used the syringe plunger to push the medication through Resident 4's G-tube, followed by a 10 ml water flushOn 7/1/2026 at 9:13 AM, LVN 3 administered to Resident 4, 30 ml of undiluted potassium chloride via G-tube, followed by a 10 ml water flushOn 7/1/2026 at 9:14 AM, LVN 3 used the syringe to draw up the LiguaCel into the syringe and used the syringe plunger to slow push the medication through Resident 4's G-tube, followed by a final flush with 30 ml of water.On 7/1/2026 at 9:17 AM, LVN 3 stated that she had finished with the medication administration to Resident 4 via G-tube. Medication was observed remaining inside of the medication cups, sticking to the bottom and sides of the medication cups. During a concurrent observation and interview on 7/1/2026 at 9:21 AM, with LVN 3 outside of Resident 4's room, LVN 3 was asked to unstack and separate the medication cups. LVN 3 stated that she sees too much medication remaining inside of each of the medication cups. LVN 3 stated that she should have mixed the medications with more water and that the resident did not receive the complete doses of each medication. LVN 3 stated the medications that were not completed administered to Resident 4 was Nitrofurantoin, Tamsulosin, LiguaCel, Docusate Sodium, Spironolactone, and Lisinopril. LVN 3 stated that Resident 4 blood pressure could go up by not receiving the full doses of the blood pressure medications.During a concurrent interview and record review on 7/1/2026 at 9:23 AM, with LVN 3, Resident 4's OSR and Medication Administration Record (MAR, a document used to track which medications a resident receives, when, and how they are administered) for the months of June 2026 and July 2026 were reviewed. LVN 3 stated Resident 4's potassium was not mixed with four ounces of water as ordered and should have been. LVN 3 stated mixing the potassium with four ounces of water was to protect the resident's stomach.During a concurrent observation and interview on 7/1/2026 at 9:27 AM, with the Director of Nursing (DON) in the presence of LVN 3, the DON looked at the medication cups and stated that Resident 4 did not get all of the medications. The DON stated that LVN 3 should have administered all of the medication inside of the medication cups to Resident 4. During a concurrent interview and record review on 7/1/2026 at 9:29 AM, with the Director of Nursing (DON), Resident 4's OSR and MAR for the months of June 2026 and July 2026 were reviewed, along with the potassium prescription labeled for Resident 4 (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and the potassium manufacturer's label. DON read the manufacturer's label for potassium chloride oral solution which included instructions on the manufacturer's medication bottle labeled for Resident 4, that indicated, Dilute Prior to Administration. DON reviewed the potassium chloride prescription labeled for Resident 4, which included an auxiliary labels that indicated, Dissolve completely in 4 to 8 oz of water or juice and This medication should be taken with plenty of water, the DON stated, that Resident 4's potassium chloride must be diluted to flush through the G-tube easily and to prevent erosion of the gastric lining of the stomach. DON provided a copy of the manufacturer's guide for potassium chloride. During a review of the facility provided undated manufacturer's labeling, Potassium Chloride Manufacturer's Guide Highlights, indicated, Dilute before use; take with meals to reduce gastrointestinal irritation. A review of the manufacturer labeling for Tamsulosin Hydrochloride, dated 2/2025, indicated that Tamsulosin hydrochloride capsules 0.4 mg once daily is recommended as the dose for the treatment of the signs and symptoms of BPH. It should be administered approximately one-half hour following the same meal each day. Tamsulosin hydrochloride capsule should not be crushed, chewed, or opened. During a review of the facility's P&P titled, Enteral Tube Medication Administration, dated 8/2014, the P&P indicated, Resident comfort due to the volume of liquid being administered during the medication administration process should also be considered. A prescriber's order may be obtained specifying the amount of liquid to be used for the flushing and administration of medications. Medications that are GI irritants (such as potassium chloride solution) are diluted as recommended for oral administration, since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes. Enteral tubes are flushed with at least 15 ml of water before administering medications and after all medications have been administered. During a review of the facility's P&P titled, Administering Medications, reviewed 3/2026, the P&P indicated, Staff follows established facility infection control procedures (e.g., handwashing, antiseptic technique, gloves, isolation precautions, etc.) for the administration of medications, as applicable. During a review of the Job Description for Director of Nursing (DON), dated 3/2025, indicated, Essential Duties and Responsibilities. Conduct regular in-service/training to ensure competent nursing staff. Evaluates the education and training needs of personnel and directs development and implementation of in-service programs through subordinate staff.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure Licensed Vocational Nurses (LVNs) received training and demonstrated competency in performing medication administration via gastrostomy tube (G-tube, care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine) prior to administering medications to three out of three sampled residents (Resident 4, Resident 32, and Resident 63). This failure had the potential to place Resident 4, Resident 32, and Resident 63 at risk for inconsistent, incomplete, or improper medication administration via G-tube, which could result in a change of condition, adverse reactions, and decline in residents' health. Findings: During an interview on 6/30/2026 at 3:43 PM with Licensed Vocational Nurse (LVN) 2, LVN 2 stated that she could not recall the last time she was observed performing a return demonstration (a process where staff show their ability to correctly perform a procedure by demonstrating it in front of an evaluator) for G-tube medication administration to residents. During an interview on 7/1/2026 at 1:26 PM with the Director of Staff Development (DSD), the DSD stated that regarding medication administration, including G-tube administration training, she was not sure if a return demonstration was conducted during the licensed nurse competency skills training. The DSD stated that she did not provide medication administration training or in-services to licensed nurses; the Director of Nursing (DON) provided the training. The DSD stated that licensed nurses are required to complete a competency upon hire, annually, and sooner than annually if the nurse needs reeducation. She stated that, a lot of times, she is not with the DON when he conducts his in-services and does not remember when the last in-service was done. During a concurrent interview and record review on 7/1/2026 at 1:53 PM with the DSD, the DSD provided the Licensed Nurse Competency Check List and stated that when the DON signed off on the licensed nurse's competency, it meant that the licensed nurse was considered competent to perform the tasks listed on the checklist. The DSD stated these tasks included medication pass administration, G-tube medication administration, hand hygiene, and PPE. During an interview on 7/2/2026 at 3:36 PM with the DON, the DON stated that he has not observed licensed nurses performing a return demonstration during their competency skill checklist. The DON stated that anything he checked off on the Licensed Nurse Competency Check List was based on discussions with the licensed nurses, not actual observation. The DON stated that without directly observing a medication pass, he cannot and should not have signed off on the competency indicating that the nurse is safe to administer medication to residents via routes not observed, including G-tube medication administration. During a review of the facility's policy and procedures (P&P) titled, Administering Medications, reviewed 3/2026, the P&P indicated, Medication errors are documented, reported, and reviewed by Quality Assurance Performance Improvement (QAPI) committee to inform process changes and or the need for additional staff training. During a review of the Job Description for Director of Nursing (DON), dated 3/2025, indicated, Essential Duties and Responsibilities. Conduct regular in-service/training to ensure competent nursing staff. Evaluates the education and training needs of personnel and directs development and implementation of in-service programs through subordinate staff.		

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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 ensure safe medication administration and accurate accountability of controlled medications (medications with a high potential for abuse) and disposal of non-controlled medications by failing to: A. Notify the physician for one of two sampled residents (Resident 4) when ferrous sulfate (a condition caused by low amounts of iron in the blood) 300 milligrams (mg, unit of measurement by weight)/ 5 milliliters (ml, unit of measurement by volume) was unavailable between 4/2026 through 6/2026 and ensure the resident was not administered the ferrous sulfate 220 mg/ 5 ml without a physician's order. B. Ensure one of two sampled residents (Resident 90's) Controlled Drug Record (CDR, a detailed record that tracks the receipt, administration, disposal, and inventory of controlled substances [use are regulated by law due to its potential for abuse, dependence, or harm]) accurately accounted for the inventory of Hydrocodone with Acetaminophen (a pain medication combining hydrocodone, an opioid, and acetaminophen, a non-opioid analgesic). C. Document the disposal of noncontrolled medications in the presence of a licensed nurse and a witness. The deficient practice created the potential for unsafe care, treatment, and medication administration which could result in Resident 4 and Resident 90 receiving more or less medication than needed to treat low iron for Resident 4, and to effectively control pain for Resident 90. The deficient practice increased the risk of not being able to readily identify controlled medication loss, drug diversion (illegal distribution or use of prescription drugs), medication errors, and safely dispose of noncontrolled medications in the facility. Findings: A. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses including Attention to Gastrostomy (G-tube), Anemia (used to treat anemia caused by low amounts of iron in the blood), and Dementia (a progressive brain disease that affects memory, thinking, and behavior). During a review of Resident 4's history and physical (H&P) dated 3/31/2026, the H&P indicated Resident 4 does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 4 was rarely or never understood or able to understand. The MDS indicated Resident 4 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a review of Resident 4's Order Summary Report (OSR) dated 7/1/2026, the OSR indicated Resident 4's prescription orders included an order for Ferrous sulfate oral solution 300 mg/ 5ml, to give 5 ml via G-tube one time a day for anemia, order date 4/5/2026, scheduled for 9 AM administration time. During a concurrent medication administration (pass) observation and interview on 7/1/2026 at 8:48 AM with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that she would have to wait and clarify Resident 4's ferrous sulfate 300 mg/ 5ml order. During a concurrent observation and interview on 7/1/2026 at 4:19 AM, with LVN 3 and the Director of Nursing (DON), LVN 3 looked through Station A, Medication Cart A and stated there was no ferrous sulfate 300 mg/5 ml available inside of the Medication Cart A. The DON stated there was no ferrous sulfate 300 mg/ 5 ml available in the facility. During an interview on 7/1/2026 at 4:40 PM with the DON, the DON stated if the facility does not have the exact dose of ferrous sulfate the physician ordered, the licensed nurse should have called and informed the physician. During an interview on 7/2/2026 at 2:37 PM with Central Supply Staff (CS) and DON, CS stated she reviewed the invoices and stated that the facility has always ordered ferrous sulfate 220 (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg/ 5 ml and there was no record that ferrous sulfate 300 mg/ 5ml was ordered and there was no request documented to order ferrous sulfate 300 mg/ 5 ml. During a review of Resident 4's Medication Administration Record (MAR, a record of each medication given, including dosage, time, and the person administering) for the months of April 2026 through July 2026 indicated by licensed nurses initials and a check mark that ferrous sulfate 300 mg /5 ml was administered to the resident 24 out of 25 times in April 2026, 31 out of 31 times in May 2026, and 30 out of 30 times in June 2026. During a concurrent interview and record review on 7/2/2026 at 2:49, with the DON, Resident 4's MAR from 4/6/2026 through 7/1/2026 was reviewed. DON stated based on the central supply not ordering and not having records of ferrous sulfate 300 mg/ 5 ml being ordered or available in the facility, indicates the facility's licensed nurses have been administering ferrous sulfate 220 mg/ 5 ml to Resident 4, since 4/6/2026 instead of the ordered dose of ferrous sulfate 300 mg/ 5ml and documenting the administration incorrectly on the resident's MARs. During a review of the facility's policy and procedure (P&P) titled Administering Medications reviewed 3/2026, the P&P indicated Medications are administered in accordance with prescribers orders. If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or facility's medical director to discuss the concerns. B. During a review of Resident 90's admission Record, the admission Record indicated Resident 90 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Peripheral Autonomic Neuropathy (damage to the nerves that control automatic body functions such as blood pressure and digestion), Paresthesia of Skin (abnormal skin sensations like tingling, prickling, or numbness), Anesthesia of Skin (loss of sensation or feeling in the skin), and Osteoarthritis (a joint disease caused by wear and tear that leads to pain and stiffness). During a review of Resident 90's H&P dated 6/5/2026, the H&P indicated Resident 90 is able to make decisions for activities of daily living. During a review of Resident 90's MDS, dated [DATE], the MDS indicated Resident 90 was cognitively intact. During a review of Resident 90's OSR dated 7/2/2026, the OSR indicated Resident 90's prescription orders included an order for Hydrocodone with Acetaminophen 5 mg/325 mg, to give one tablet by mouth every six (6) hours as needed for severe pain due to leg neuropathy ([7-10] pain scale refers to pain that is rated as severe on a standard 0-10 scale, where 0 means no pain and 10 means the worst pain imaginable). Not to exceed three (3) grams (gm, unit of measurement by weight) per day of Acetaminophen, order dated 3/17/2026. During a concurrent medication storage inspection and interview on 7/1/2026 at 2:34 PM, with LVN 6 on Station B, Medication Cart B, Resident 90's CDR for Hydrocodone with Acetaminophen 5 mg/ 325 mg was reviewed. Resident 90's CDR form included a skipped line and an out of date sequence on the controlled inventory form. Resident 90's CDR form indicated on: CDR line 20 documented removal of a dose of Hydrocodone with Acetaminophen 5 mg/ 325 mg on 6/30/2026, timed at 8:03 AM CDR line 19 documented removal of a dose of Hydrocodone with Acetaminophen 5 mg/ 325 mg on 7/1/2026, timed at 8:09 AM CDR line 18, was skipped, left empty CDR line 17 documented a wasted dose of Hydrocodone with Acetaminophen 5 mg/ 325 mg on 6/29/2026, timed at 2300 (11:00 PM) LVN 6 stated a licensed nurse skipped a line and left line 18 empty on the CDR. LVN 6 stated that she was not sure how to mark the next dose to be given on the CDR since a line was skipped and the dates are out of sequential order. During a concurrent interview and record review on 7/2/2026 at 1:12 PM, with the DON, the DON reviewed Resident 90's CDR and stated that the licensed nurses must use the controlled drug record chronologically and must not skip a line. DON stated skipping a line on the CDR can cause confusion, increasing potential for medication diversion. DON stated the licensed nurses must accurately account for controlled medication usage sequentially to prevent medication errors or confusion or diversion. During a review of the facility's (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P&P titled Controlled Medications reviewed 3/2026, the P&P indicated, When a dose of a controlled medication is removed from the container for administration but refused by the resident or not given for any reason. It is not placed back in the container. It is destroyed in the presence of two licensed nurses, and the disposal is documented on the accountability record on the line representing that dose. The same process applies to the disposal of unused partial tablets and unused portions of single dose ampules and does of controlled substances wasted for any reason. C. During a concurrent observation of medication storage areas and interview on 7/1/2026 at 4:05 PM, with LVN 3 on Station A the medication room was inspected. Inside of Station A medication room was the noncontrolled medication disposal log that included one licensed nurse's initials or signature for the disposal of noncontrolled medications dated between 3/2026 to 6/2026. LVN 3 stated the noncontrolled medication disposal log was missing a second licensed nurse or a witness for the disposal of the noncontrolled medications. During a concurrent interview and record review on 7/2/2026 at 2:35 PM with the DON, Station A Medication Room noncontrolled medication disposal logs were reviewed. DON stated that two nurses must perform noncontrolled medication disposal together. DON stated one nurse cannot sign as their own witness, as two nurses are necessary to verify and ensure the noncontrolled medications are being destroyed according to the facility's process. During a review of the facility's P&P titled Medication Destruction reviewed 3/2026, the P&P indicated, Non-controlled medication destruction occurs in the presence of two licensed nurses. The nurse (s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form. Date of destruction Resident's name Name and strength of medication Prescription number Amount of medication destroyed Signatures of witnesses		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%). Five medication errors of 28 total opportunities contributed to an overall medication error rate of 17.86 % affecting three of five residents observed for medication administration (Resident 4, Resident 44, and Resident 63). The medication errors noted were as follows: A. For Resident 4, facility licensed nurse did not dilute potassium chloride (used to treat low blood potassium) prior to administration via gastrostomy tube (G-tube, care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine) in accordance with manufacturer's specification and physician's order. B. Facility failed to ensure the correct medication dose of ferrous sulfate (used to treat anemia caused by low amounts of iron in the blood) was available and administered to Resident 4 between 4/2026 - 6/2026 as ordered. C. For Resident 63, facility licensed nurse did not check heart rate (HR, the number of times the heart beats per minute) prior to administration of metoprolol (used to treat high blood pressure, chest pain, and heart failure) 50 mg as ordered. D. For Resident 63, facility licensed nurse did not check respiration rate (RR, the number of breaths taken per minute [bpm]) or ensure the pain level was within the ordered parameter prior to administration of tramadol (a controlled medication [or controlled substance, regulated by the government because it carries a risk of misuse, addiction, or physical dependence] used to manage moderate to severe pain) 50 mg as ordered. E. For Resident 44, facility licensed nurse did not check HR prior to administration of metoprolol 50 mg as ordered. These failures had the potential to result in ineffective pain and/ or blood pressure management of Resident 63 and Resident 44, and increased Resident 4's risk of gastrointestinal conditions with the administration of undiluted potassium chloride via G-tube. These failures placed Resident 4, Resident 44, and Resident 63 at risk for uncontrolled symptoms, weakness, deterioration in condition, and the need for additional medical interventions. Findings: A. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses including Attention to Gastrostomy (G-tube), Ileus (a condition where the intestines do not move food and waste normally, causing blockage and discomfort), Hypokalemia (low levels of potassium in the blood, which can lead to weakness, tiredness, or cramps), hypertension (high blood pressure), Anemia (used to treat anemia caused by low amounts of iron in the blood), Gastro-esophageal Reflux disease (GERD, a condition where stomach acid frequently flows back into the tube connecting the mouth and stomach, causing heartburn and irritation), and Dementia (a progressive brain disease that affects memory, thinking, and behavior). During a review of Resident 4's history and physical (H&P) dated 3/31/2026, the H&P indicated Resident 4 does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 4 was rarely or never understood or able to understand. The MDS indicated Resident 4 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a medication administration (pass) observation on 7/1/2026 between 8:22 AM to 8:51 AM, with Licensed Vocational Nurse (LVN) 3 on Station A, at Medcart A, LVN 3 prepared the following medications for Resident 4: spironolactone (a potassium-sparing diuretic [water pill]) 50 milligram (mg, unit of measurement by weight) oral tablet, one tablet; lisinopril (treat high blood pressure) 5 mg oral tablet, one tablet; LiquaCel (protein supplement) 16 gram (gm, unit of measurement (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by weight) ProteinDocusate sodium (stool softener) 100 mg oral tablet, one tabletNitrofurantoin (antibiotic) 100 mg oral capsule, one capsuleTamsulosin (treat benign prostatic hyperplasia [BPH] enlarged prostate that can cause difficulty urinating, painful urination or increased urinary frequency or urgency) 0.4 mg oral capsule, one capsulePotassium chloride oral solution 10 percent (%) 20 milliequivalents (mEq, unit of measurement) per 15 milliliters (ml, unit of measurement by volume), 30 ml (40 mEq)Ferrous sulfate 300 mg/ 5ml, 5 ml, not observed available in the medication cart During a medication administration (pass) observation on 7/1/2026 between 8:54 AM to 9:17 AM, LVN 3 entered Resident 4's room to administer the prepared medications. LVN 3 was observed administering the 30 ml of undiluted potassium chloride via G-tube alone with the other prepared medications with flushing in between each medication with 5 to 10 ml of water. During a review of Resident 4's Order Summary Report (OSR) dated 7/1/2026, the OSR indicated Resident 4's prescription orders included, but was not limited to:1. Potassium chloride oral solution 20 mEq/15 ml (10 %), to give 30 ml via G-tube one time a day for hypokalemia (low blood potassium). Give 40 mEq = 30 ml, dilute with 4 (four) ounces (oz, unit of measurement by volume) of water prior to administering, order date 4/5/2026. 2. Ferrous sulfate oral solution 300 mg/ 5ml, to give 5 ml via G-tube one time a day for anemia, order date 4/5/2026, scheduled for 9 AM administration time.During a concurrent interview and record review on 7/1/2026 at 9:23 AM, with LVN 3, Resident 4's OSR and Medication Administration Record (MAR, a document used to track which medications a resident receives, when, and how they are administered) for the months of June 2026 and July 2026 were reviewed. LVN 3 stated Resident 4's potassium was not mixed with four ounces of water as ordered and should have been. LVN 3 stated mixing the potassium with four ounces of water was to protect the resident's stomach. During a concurrent interview and record review on 7/1/2026 at 9:27 AM, with the Director of Nursing (DON), Resident 4's OSR and MAR for the months of June 2026 and July 2026 were reviewed, along with the potassium prescription labeled for Resident 4 and the potassium manufacturer's label. DON read the manufacturer's label for potassium chloride oral solution which included instructions on the manufacturer's medication bottle labeled for Resident 4, that indicated, Dilute Prior to Administration. DON reviewed the potassium chloride prescription labeled for Resident 4, which included an auxiliary labels that indicated, Dissolve completely in 4 to 8 oz of water or juice and This medication should be taken with plenty of water, the DON stated, that Resident 4's potassium chloride must be diluted to flush through the G-tube easily and to prevent erosion of the gastric lining of the stomach. DON provided a copy of the manufacturer's guide for potassium chloride. During a review of the facility provided undated manufacturer's labeling, Potassium Chloride Manufacturer's Guide Highlights, indicated, Dilute before use; take with meals to reduce gastrointestinal irritation. B. During a concurrent medication administration (pass) observation and interview on 7/1/2026 at 8:48 AM with LVN 3, LVN 3 stated that she will have to wait and clarify Resident 4's ferrous sulfate 300 mg/ 5ml order.During a concurrent observation and interview on 7/1/2026 at 4:19 AM, with LVN 3 and DON, LVN 3 looked through Station A, Medication Cart A and stated there was no ferrous sulfate 300 mg/5 ml available inside of the Medication Cart A. The DON stated there was no ferrous sulfate 300 mg/ 5 ml available in the facility.During an interview on 7/1/2026 at 4:40 PM with the DON, the DON stated if the facility does not have the exact dose of ferrous sulfate the physician ordered, the licensed nurse should have called and informed the physician.During a concurrent interview and record review on 7/1/2026 at 5:07 PM with the DON and the Central Supply Staff (CS), Resident 4's MAR for the months of April 2026 through July 2026 were reviewed. Resident 4's MARs were documented with LVNs initials to indicate Resident 4's ferrous sulfate 300 mg/ 5ml was administered daily for the scheduled 9 AM administration time. CS showed a (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottle of ferrous sulfate 220 mg/ 5ml and stated that is what was picked up today, 7/1/2026 and has been in stock at the facility. DON stated that Resident 4 did not receive ferrous sulfate 300 mg/ 5 ml, because the medication was not available. During an interview on 7/2/2026 at 2:37 PM with CS and DON, CS stated she reviewed the invoices and stated that the facility has always ordered ferrous sulfate 220 mg/ 5 ml and there was no record that ferrous sulfate 300 mg/ 5ml was ordered and there was no request documented to order ferrous sulfate 300 mg/ 5 ml. During a review of Resident 4's MAR for the months April 2026 through July 2026 indicated by licensed nurses initials and a check mark that ferrous sulfate 300 mg /5 ml was administered to the resident 24 out of 25 times in April 2026, 31 out of 31 times in May 2026, and 30 out of 30 times in June 2026. During a concurrent interview and record review on 7/2/2026 at 2:49, with the DON, Resident 4's MAR from 4/6/2026 through 7/1/2026 was reviewed. DON stated based on the central supply not ordering and not having records of ferrous sulfate 300 mg/ 5 ml being ordered or available in the facility, indicates the facility's licensed nurses has been administering ferrous sulfate 220 mg/ 5 ml since 4/6/2026 instead of the ordered dose of ferrous sulfate 300 mg/ 5ml and documenting the administration incorrectly on the resident's MARs. C. During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Attention to Gastrostomy (care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine), Dementia (a progressive brain disease that affects memory, thinking, and behavior), Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar), Hypertension (high blood pressure), and Long Term (Current) use of Opiate Analgesic (a controlled medication used to relieve pain). During a review of Resident 63's history and physical (H&P) dated 12/20/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions. During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 63 was severely cognitively impaired. The MDS indicated Resident 63 was dependent (helper provides all of the effort) for all aspects of activities of daily living (ADLs, routine tasks/activities such as eating, oral and personal hygiene, toileting, bathing, dressing, and transfer, tasks a person performs daily to care for themselves). During a review of Resident 63's OSR dated 6/30/2026, the OSR indicated physician's orders for: Metoprolol Tartrate 50 mg, one tablet via G-tube one time a day for hypertension (Blood pressure above the reference range 120/80 millimeters mercury [mm/hg a unit of measure of pressure] - 130/80 mm/hg) hold for Systolic ([SBP] - the pressure caused by heart while contracting) of less than 110 mm/hg or HR (HR, reference range for a normal adult heart rate is typically 60-100 bpm, with values below 60 bpm considered bradycardia [slow heart rate]) less than 60 bpm, give with food, order dated 10/26/2024. Tramadol 50 mg, one tablet via G-tube twice a day for severe pain (7-10). Hold if drowsy or RR (reference range 12-20 breaths per minute [bpm], with values below 12 bpm considered bradypnea (abnormally slow breathing) less than 12 bpm. Document pain site in the Progress Notes, order dated 3/17/2026. During a review of Resident 63's Care Plans indicated: Resident 63 was at risk for cardiac distress related to hypertension. pacemaker status. At risk for irregular pulse, elevated blood pressure (BP). hypotension (low blood pressure). revised on 6/29/2026. Resident 63's Care Plan indicated, resident will have no unrecognized signs and symptoms of cardiac distress daily. Give medication as ordered. Monitor pulse rate and blood pressure as ordered. Resident 63 was at risk for adverse effects from Black Box Medication [Tramadol], revised on 6/2/2026. Resident 63's Care Plan indicated resident's risk for the use of Black Box medication (s) will be monitored/identified by licensed nurse. MD will be notified promptly. Risk of opioid addiction, abuse and misuse, which can lead to overdose and death. Serious life threatening, or (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER View Park Convalescent Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Don Felipe Drive Los Angeles, CA 90008	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	fatal respiratory depression may occur with use. Monitor for respiratory depression.may result in profound sedation, respiratory depression, coma and death During a concurrent medication administration (pass) observation and interview on 6/30/2026 between 9:39 AM to 10:20 AM, with LVN 1, LVN 1 prepared Resident 63's medications that included but was not limited to metoprolol 50 mg and tramadol 50 mg. LVN 1 entered Resident 63's room, checked the resident's blood pressure and stated the blood pressure was 134/68 mmhg. LVN 1 was not observed checking Resident 63's HR (also called pulse rate) or RR prior to administering to the resident metoprolol and tramadol to the resident. During an interview on 6/30/2026 at 10:18 AM with LVN 1, LVN 1 stated that Resident 63's HR should have been checked prior to administering the blood pressure medication, metoprolol. LVN 1 stated it was important to check both the blood pressure and heart rate to prevent Resident 63 from becoming hypotensive or experiencing any cardiac or medical issues. D. During a concurrent interview and record review on 6/30/2026 at 2:44 PM with LVN 1, Resident 63's OSR, MAR, and Progress Notes for the month of June 2026, were reviewed for the use of tramadol. LVN 1 stated, for Resident 63, the physician ordered tramadol to be administered twice a day for severe pain of 7 to 10 on a pain scale of 10 being very severe pain, and to hold for drowsiness, or RR less than 12, and to document the pain site in the progress notes. LVN 1 stated that Resident 63's RR was not checked prior to the administration of tramadol as ordered and the pain level was documented in the MAR as zero (0) on 6/30/2026 for the scheduled 9 AM administration of tramadol, which was outside of the physician's ordered parameter to administer. During a review of the facility's pain scale of 0 to 10 indicated a pain assessment level of: 0 = no pain 1- 3 = mild pain 4 - 6 = moderate pain 7 - 9 = severe pain, and 10 = very severe pain During a concurrent interview and record review on 6/30/2026 at 2:58 PM with a Registered Nurse (RNS) 1, Resident 63's OSR and prescription label for tramadol was reviewed. Resident 63's prescription label for tramadol indicated to administer tramadol 50 mg every 12 hours (routine) for moderate pain, with a fill date of 6/2/2026. RNS 1 stated there was no documentation that the pharmacy or the physician was called when there was discrepancy between the physician's order and the prescription label. During a concurrent telephone interview and record review on 6/30/2026 at 3:27 PM, in the presence of the DON, the facility's dispensing pharmacist (Pharm) 2 was called and Resident 63's physician order and prescription label for tramadol 50 mg was reviewed. Pharm 1 reviewed the initial order sent from the facility to the pharmacy and stated on 3/17/2026 which included the physician's parameters hold tramadol if Resident 63 was drowsy, or RR was less than 12, and to give for pain level of 7 to 10. Pharm 2 stated the pharmacy should have included the physician hold parameters on Resident 63's tramadol prescription label. Pharm 2 stated the rationale for holding tramadol if drowsy or RR is less than 12 is because tramadol can slow the resident's breathing and cause respiratory depression and it is crucial to include the parameters on the prescription label. E. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including Hypertension (high blood pressure). During a review of Resident 44's history and physical (H&P) dated 5/17/2026, the H&P indicated Resident 44 has the capacity for medical decision making. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 44 has the ability to understand and be understood. The MDS indicated Resident 44 was dependent (helper provides all effort) for toileting, required substantial assistance (Helper provides more than half the effort) for bathing and personal hygiene and required setup for eating and oral hygiene. During a review of Resident 44's OSR dated 6/30/2026, the OSR indicated physician's order for metoprolol tartrate 50 mg, one tablet by mouth two times a day for hypertension. Hold for SBP less than 100 mmhg or HR less than 60. Give with food, order dated 6/13/2026 During a (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	concurrent medication administration (pass) observation and interview on 6/30/2026 between 8:40 AM to 8:53 AM, with LVN 2, LVN 2 prepared Resident 44's medications that included but was not limited to metoprolol 50 mg. LVN 2 entered Resident 44's room, checked the resident's blood pressure and stated the blood pressure was 126/74 mmhg. LVN 2 was not observed checking Resident 44's HR. Resident 44 took all medications by mouth. During an interview on 6/30/2026 at 10:31 AM, with LVN 2, LVN 2 stated that Resident 44's HR was not checked prior to administering metoprolol during morning medication pass on 6/30/2026, and the resident's HR should have been checked. LVN 2 stated the physician's order had a parameter to hold the blood pressure medication, metoprolol for HR less than 60 bpm. LVN 2 stated if the HR was to go too low, could cause Resident 44 to experience an adverse reaction. During an interview on 7/2/2026 at 2:18 PM, with DON, DON stated if resident (Resident 44) was given metoprolol with a low HR, the medication could cause the resident's HR to drop further and lead to bradypnea. DON stated residents' vital sign (a measurement of basic body functions, such as blood pressure, heart rate, temperature, and breathing rate, used to assess a person's health) should be taken before administering medications with an ordered parameter which is used to determine whether to give or not give a medication. During a review of the facility's policy and procedure (P&P) titled Administering Medications revised 3/2023, the P&P indicated .4. Medications are administered in accordance with prescribers orders, including any required time frame.6. Medication errors are documented, reported, and reviewed by the QAPI committee to inform process changes and or the need for additional staff training.8. If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or facility's medical director to discuss the concerns.10. The following information is checked/ verified for each resident prior to administering medications. vital signs, if necessary. During a review of the facility's P&P titled, Enteral Tube Medication Administration, dated 8/2014, the P&P indicated, Medications that are GI irritants (such as potassium chloride solution) are diluted as recommended for oral administration, since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes. During a review of the facility's P&P titled, Ordering and Receiving Medications From the Dispensing Pharmacy, dated 1/2022, the P&P indicated, Receiving Medications from the Pharmacy.1. A licensed nurse.b. Verifies medications received and directions for use with the medication order form and/ or physician's orders. c. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor. During a review of the facility's P&P titled Provider Pharmacy Requirements, dated 1/2025, the P&P indicated, The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to.Accurately dispensing prescriptions based on authorized prescriber orders. Providing medications packaged in accordance with the facility's needs.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of five residents (Resident 4 Resident 63) were free of a significant medication error (any preventable error in medication administration that can result in resident discomfort, jeopardizing health and safety, or requiring medical intervention) by failing to: A. Ensure Resident 4's potassium chloride (used to treat low blood potassium) was diluted with water prior to administration via gastrostomy tube (G-tube, care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine) on 7/1/2026, in accordance with manufacturer's specification and physician's order. B. Ensure Resident 63's respiration rate (RR, the number of breaths taken per minute [bpm]) and the pain level were within the ordered parameter prior to administration of tramadol (a controlled medication [or controlled substance, regulated by the government because it carries a risk of misuse, addiction, or physical dependence] used to manage moderate to severe pain) in accordance with physician's order. These failures had the potential to result ineffective or excessive use of a controlled pain medication for Resident 63 and increased risk of Resident 4 experiencing stomach or gastrointestinal (GI) irritations with the administration of undiluted potassium chloride via G-tube. These failures placed Resident 4 and Resident 63 at risk for uncontrolled symptoms, weakness, deterioration in condition, and the need for additional medical interventions. Findings: A. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] with readmission on [DATE] with diagnoses including Attention to Gastrostomy (G-tube), Ileus (a condition where the intestines do not move food and waste normally, causing blockage and discomfort), Hypokalemia (low levels of potassium in the blood, which can lead to weakness, tiredness, or cramps), and Gastro-esophageal Reflux disease (GERD, a condition where stomach acid frequently flows back into the tube connecting the mouth and stomach, causing heartburn and irritation). During a review of Resident 4's history and physical (H&P) dated 3/31/2026, the H&P indicated Resident 4 does not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 4 was rarely or never understood or able to understand. The MDS indicated Resident 4 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a medication administration (pass) observation on 7/1/2026 between 8:22 AM to 8:51 AM, with Licensed Vocational Nurse (LVN) 3 on Station A, at Medcart A, LVN 3 prepared Resident 4's morning medications that included potassium chloride oral solution 10 percent (%) 20 milliequivalents (mEq, unit of measurement) per 15 milliliters (ml, unit of measurement by volume), 30 ml (40 mEq). During a medication administration (pass) observation on 7/1/2026 between 8:54 AM to 9:17 AM, LVN 3 entered Resident 4's room to administer the prepared medications. LVN 3 was observed administering the 30 ml of undiluted potassium chloride via G-tube alone with the other prepared medications with flushing in between each medication with 5 to 10 ml of water. During a review of Resident 4's Order Summary Report (OSR) dated 7/1/2026, the OSR indicated Resident 4's prescription orders included an order for Potassium chloride oral solution 20 mEq/15 ml (10 %), to give 30 ml via G-tube one time a day for hypokalemia (low blood potassium). Give 40 mEq = 30 ml, dilute with 4 (four) ounces (oz, unit of measurement by volume) of water prior to administering, order date 4/5/2026. During a review of Resident 4's Care Plans indicated: Resident 4 is on G-tube feeding, and at risk for aspiration, nausea and vomiting, abdominal distention, diarrhea, (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	constipation.revised 5/3/2026. Resident 4's care plan indicated, flush G-tube with water as ordered.Resident 4 is at risk for GI distress or bleeding secondary to GERD, revised 4/8/2026. Resident 4's care plan indicated, assess for signs and symptoms of GI distress, such as nausea and vomiting, abdominal pain, abdominal distention, reflux, bleeding.and notify MD. Administer medication as ordered.Resident 4 is at risk for serum potassium variation, revised 4/8/2026. Resident 4's care plan indicated to administer medications as ordered. During a concurrent interview and record review on 7/1/2026 at 9:23 AM, with LVN 3, Resident 4's OSR and Medication Administration Record (MAR, a document used to track which medications a resident receives, when, and how they are administered) for the months of June 2026 and July 2026 were reviewed. LVN 3 stated Resident 4's potassium was not mixed with four ounces of water as ordered and should have been. LVN 3 stated mixing the potassium with four ounces of water was to protect the resident's stomach. During a concurrent interview and record review on 7/1/2026 at 9:27 AM, with the Director of Nursing (DON), Resident 4's OSR and MAR for the months of June 2026 and July 2026 were reviewed, along with the potassium prescription labeled for Resident 4 and the potassium manufacturer's label. DON read the manufacturer's label for potassium chloride oral solution which included instructions on the manufacturer's medication bottle labeled for Resident 4, that indicated, Dilute Prior to Administration. DON reviewed the potassium chloride prescription labeled for Resident 4, which included an auxiliary labels that indicated, Dissolve completely in 4 to 8 oz of water or juice and This medication should be taken with plenty of water, the DON stated, that Resident 4's potassium chloride must be diluted to flush through the G-tube easily and to prevent erosion of the gastric lining of the stomach. DON provided a copy of the manufacturer's guide for potassium chloride.During a review of the facility provided undated manufacturer's labeling, Potassium Chloride Manufacturer's Guide Highlights, indicated, Dilute before use; take with meals to reduce gastrointestinal irritation. During a review of the facility's P&P titled, Enteral Tube Medication Administration, dated 8/2014, the P&P indicated, Medications that are GI irritants (such as potassium chloride solution) are diluted as recommended for oral administration, since there is a high potential for gastric irritation when medications are administered directly into the stomach through enteral tubes. B. During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Attention to Gastrostomy (care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine), Dementia (a progressive brain disease that affects memory, thinking, and behavior), Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar), Hypertension (high blood pressure), and Long Term (Current) use of Opiate Analgesic (a controlled medication used to relieve pain). During a review of Resident 63's history and physical (H&P) dated 12/20/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions.During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 63 was severely cognitively impaired. The MDS indicated Resident 63 was dependent (helper provides all of the effort) for all aspects of activities of daily living (ADLs, routine tasks/activities such as eating, oral and personal hygiene, toileting, bathing, dressing, and transfer, tasks a person performs daily to care for themselves). During a review of Resident 63's OSR dated 6/30/2026, the OSR included a physician's order for tramadol 50 mg, one tablet via G-tube twice a day for severe pain (7-10). Hold if drowsy or RR (reference range 12-20 breaths per minute [bpm], with values below 12 bpm considered bradypnea (abnormally slow breathing) less than 12 bpm. Document pain site in the Progress Notes, order dated 3/17/2026. During a review of Resident 63's Care Plans indicated that Resident 63 was at risk for adverse effects from Black Box Medication [Tramadol], (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised on 6/2/2026. Resident 63's Care Plan indicated resident's risk for the use of Black Box medication (s) will be monitored/identified by licensed nurse. MD will be notified promptly. Risk of opioid addiction, abuse and misuse, which can lead to overdose and death. Serious life threatening, or fatal respiratory depression may occur with use. Monitor for respiratory depression. may result in profound sedation, respiratory depression, coma and death. During a concurrent medication administration (pass) observation and interview on 6/30/2026 between 9:39 AM to 10:20 AM, with LVN 1, LVN 1 prepared Resident 63's medications that included but was not limited to metoprolol 50 mg and tramadol 50 mg. LVN 1 entered Resident 63's room, checked the resident's blood pressure and stated the blood pressure was 134/68 mmhg. LVN 1 was not observed checking Resident 63's HR (also called pulse rate) or RR prior to administering to the resident metoprolol and tramadol to the resident. During a concurrent interview and observation on 6/30/2026 at 9:57 AM, LVN 1 asked Resident 63 if experiencing pain. Resident 63 stated, fine and not in pain. During a concurrent interview and record review on 6/30/2026 at 2:44 PM with LVN 1, Resident 63's OSR, MAR, and Progress Notes for the month of June 2026, were reviewed for the use of tramadol. LVN 1 stated, for Resident 63, the physician ordered tramadol to be administered twice a day for severe pain of 7 to 10 on a pain scale of 10 being very severe pain, and to hold for drowsiness, or RR less than 12, and to document the pain site in the progress notes. LVN 1 stated that Resident 63's RR was not checked prior to the administration of tramadol as ordered and the pain level was documented in the MAR as zero (0) on 6/30/2026 for the scheduled 9 AM administration of tramadol, which was outside of the physician's ordered parameter to administer. During a review of the facility's pain scale of 0 to 10 indicated a pain assessment level of: 0 = no pain 1 - 3 = mild pain 4 - 6 = moderate pain 7 - 9 = severe pain, and 10 = very severe pain. During a concurrent interview and record review on 6/30/2026 at 2:58 PM with a Registered Nurse (RNS) 1, Resident 63's OSR and prescription label for tramadol was reviewed. Resident 63's prescription label for tramadol indicated to administer tramadol 50 mg every 12 hours (routine) for moderate pain, with a fill date of 6/2/2026. RNS 1 stated there was no documentation that the pharmacy or the physician was called when there was discrepancy between the physician's order and the prescription label. During a concurrent telephone interview and record review on 6/30/2026 at 3:27 PM, in the presence of the DON, the facility's dispensing pharmacist (Pharm) 2 was called and Resident 63's physician order and prescription label for tramadol 50 mg was reviewed. Pharm 1 reviewed the initial order sent from the facility to the pharmacy and stated on 3/17/2026 which included the physician's parameters hold tramadol if Resident 63 was drowsy, or RR was less than 12, and to give for pain level of 7 to 10. Pharm 2 stated the pharmacy should have included the physician hold parameters on Resident 63's tramadol prescription label. Pharm 2 stated the rationale for holding tramadol if drowsy or RR is less than 12 is because tramadol can slow the resident's breathing and cause respiratory depression and it is crucial to include the parameters on the prescription label. During a concurrent interview and record review on 7/2/2026 at 2:01 PM with DON, Resident 63's June 2026, MAR was reviewed. The DON stated the documented pain level for Resident 63 for the scheduled 9 AM administration on 6/30/2026 was documented by licensed nurse's initials as zero (0). DON stated the pain level for Resident 63 was not within the parameter to administer tramadol and the physician ordered was to give for severe pain between 7 to 10. Resident 63, June 2026 MAR indicated by documentation and licensed nurses initials that Resident 63 was administered tramadol 50 mg a total of 17 times with a pain level of zero (0) outside of the ordered parameter for severe pain (on a pain scale of 7 to 10 out of 10) as follow: For the scheduled 9 AM administration of tramadol Resident 63's pain level was documented as zero (0) on 6/1/2026, 6/7/2026, 6/14/2026, 6/21/2026, 6/29/2026, and 6/30/2026; For the scheduled 6 PM administration (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of tramadol Resident 63's pain level was documented as zero (0) on 6/2/2026, 6/3/2026, 6/8/2026, 6/9/2026, 6/10/2026, 6/14/2026, 6/15/2026, 6/20/2026, 6/21/2026, 6/26/2026, and 6/27/2026 During a review of the facility's policy and procedure (P&P) titled Administering Medications revised 3/2023, the P&P indicated, Medications are administered in accordance with prescribers orders. If a dosage is believed to be inappropriate or excessive for a resident, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or facility's medical director to discuss the concerns. The following information is checked/ verified for each resident prior to administering medications. vital signs, if necessary. During a review of the facility's P&P titled, Ordering and Receiving Medications From the Dispensing Pharmacy, dated 1/2022, the P&P indicated, Receiving Medications from the Pharmacy. A licensed nurse. Verifies medications received and directions for use with the medication order form and/ or physician's orders. Promptly reports discrepancies and omissions to the issuing pharmacy and the charge nurse/supervisor.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the menu and did not meet nutritional needs of the residents when [NAME] 1 added additional gravy to the Swedish meatballs instead of two (2) ounces (oz, unit of measurement) of gravy as indicated on the menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) This failure had the potential to result in increased of food and nutrient intake to 53 of 84 residents on regular, therapeutic diets (a personalized meal plan prescribed by a healthcare professional or registered dietitian that controls the intake of specific foods or nutrients), resulting in unplanned weight gain. Findings: During a review of the facility's menu spreadsheet titled Summer Menus, dated 6/29/2026, the spreadsheet indicated residents on regular texture would include the following foods on the tray: Swedish meatballs 2 oz Gravy 1-2 oz Egg noodles 1/2 cup (c, a household measurement) Fresh zucchini and carrots 1/2 c Orange slices 1 piece Wheat roll 1 piece Margarine 1 teaspoon (tsp, a household measurement) Raspberry parfait square 2x2 1/2 inch Milk 4 oz During an observation on 6/29/2026 at 12:16 p.m., of the lunch tray-line (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) service, observed [NAME] 1 use a 2 oz ladle for serving gravy for the first cart (14 residents) and adding more gravy when scooping the meatballs with the use of serving spoon. During a concurrent observation and interview on 6/29/2026 at 12:17 p.m., of [NAME] 1 serving the Swedish meatballs and gravy with the Registered Dietitian (RD), observed [NAME] 1 use 2 oz ladle to serve gravy and adding more gravy by scooping the meatballs with gravy using a serving spoon. The RD stated [NAME] 1 was putting a bit too much of the gravy on the plate. The RD stated the resident's menu is designed to meet the nutritional needs of the residents and if there is excess gravy on the plate, it could potentially lead to weight gain for the residents if the practice continues. During a review of the facility's policies and procedures (P&P) titled, Menu, dated 3/20/2026, the P&P indicated, The standard menu will ensure nutritional adequacy of all diets, offer a variety of food in adequate amounts at each meal, and a standardized food production. (1) Menus are planned to meet the Recommended Dietary Allowances of the Food and Nutrition Board, National Research Council, adjusted to the age, activity and environment of the group involved. (5) the menus will be prepared as written using standardized recipes. The dietary services supervisor and cooks are trained and responsible for the preparation and service of therapeutic diets prescribed. During a review of the facility's standardized recipe titled, Recipe: Swedish Meatballs, dated 3/20/2026, the recipe indicated, the portion size of the gravy is approximately 1-2 oz and direction to for serving the gravy is to serve 2 meatballs and 1-2 oz gravy over egg noodles. During a review of the facility's P&P titled, Meal Service, dated 3/20/2026, the P&P indicated, 3. Foods are portioned using the proper utensil according to the menu spreadsheet.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to Implement and maintain an effective infection prevention and control program by failing to:1. Ensure Licensed Vocational Nurses (LVNs) followed the facility's policy and procedures titled, Enhanced Barrier Precautions, and Handwashing/Hand Hygiene, during medication administration for four of five residents (Resident 32, Resident 44, 63, and Resident 74) observed during the medication administration task.2. Ensure staff wore appropriate personal protective equipment (PPE- specialized gear designed to act as a physical barrier between a healthcare worker and potentially infectious materials like blood, body fluids, and airborne germs not limited to gloves, gown) when providing care to one of one sampled (Resident 70) who was on enhanced barrier precaution (EBP, an infection control practice that involves wearing gowns and gloves during high-contact activities with residents in nursing homes) according to the facility's policy and procedures (P&P) titled, Infection Control dated 3/20/2026.This deficient practice increased the potential to result in the transmission of infectious agents in the facility and placed Residents 32, 44, 63, 70 and 74, other residents, and staff, and guests at risk for infections. Findings: 1A. During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] with diagnoses including Attention to Gastrostomy (care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine), polyneuropathy (nerve damage affecting multiple nerves, often causing weakness, numbness, or pain), osteoarthritis (a joint disease causing pain and stiffness), right ankle and foot During a review of Resident 32's history and physical (H&P) dated 11/7/2027, the H&P indicated Resident 32 does not have the capacity to understand and make decisions During a review of Resident 32's Minimum Data Set (MDS, a resident assessment tool), dated 10/10/2025, the MDS indicated Resident 32 was severely cognitively (has serious difficulty with thinking, memory, or understanding) impaired. The MDS indicated Resident 32 was totally dependent upon staff physical assistance for all activities of daily living (ADLs, basic personal everyday activities including, but not limited to, tasks such as eating, toileting, grooming, dressing, bathing, and transferring). During a concurrent medication pass observation and interview on 6/30/2026 between 8:18 AM to 8:36 AM, with LVN 2, on Station B, Medication Cart C, LVN 2 after preparing medications for Resident 32, LVN 2 entered the resident's room without putting on a gown. LVN 2 stated that she was checking Resident 32's G-tube for placement, for residual, and then administered two morning medications via G-tube. Observed on the wall outside of Resident 32's room was a sign that indicated, Enhanced Barrier Precaution, which directed the nurse to wear Personal Protective Equipment (PPE, gown and gloves) during high contact care for the resident. LVN 2 was not observed wearing a gown before entering Resident 32's room, or while touching the resident's stomach and G-tube, or during the administration of medication through the opened valve of the G-tube, or while touching the resident and the resident's environment during the course of providing care and treatment directly to the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident. During an interview on 6/30/2026 at 2:30 PM with the Director of Nursing (DON), the DON was asked about the Enhanced Barrier Precaution (EBP) sign just outside of Resident 32's room. DON stated the EBP sign was for Resident 32 who received nutrients and medications via G-tube and skin was compromised. DON stated licensed nurses providing care to Resident 32 must wear gown and gloves. During an interview on 6/30/2026 at 2:33 PM, with the facility's Infection Preventionist (IP), the IP stated the EBP sign for Resident 32 is to be observed by licensed nurses providing direct resident care. IP stated that direct resident care included but not limited to dressing changes for wound or skin care, changing of bed sheets, providing range of motion exercises, and providing medications administration via G-tube. IP stated it was important for licensed nurses and staff to wear PPE (gown and gloves) when caring for Resident 32 and other residents with open portals to protect the residents and to prevent any transmission of infections or organism from into through the resident's open portals, such as the G-tube (a feeding tube inserted into the stomach), wounds (breaks in the skin), colostomy (an opening in the abdomen for waste to exit the body), or via foley catheter (a tube placed in the bladder to drain urine). During an interview on 6/30/2026 at 3:43 PM, with LVN 2, LVN 2 stated she should have followed the Enhanced Barrier Precaution (EBP) practices by wearing a gown when administering G-tube medications to Resident 32. LVN 2 stated that she could not recall the last time she was observed performing a return demonstration for G-tube medication administration to residents. 1B. During a review of Resident 44's admission Record, the admission Record indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including History of (healed traumatic fracture [a broken bone caused by an injury that has fully recovered]), Orthopedic Aftercare (medical follow-up and treatment after bone, joint, or muscle injuries or surgery), Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar), and Hypertension (high blood pressure). During a review of Resident 44's history and physical (H&P) dated 5/17/2026, the H&P indicated Resident 44 has the capacity for medical decision making. During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 5/20/2026, the MDS indicated Resident 44 has the ability to understand and be understood. During a medication pass observation on 6/30/2026 at 8:38 AM, with LVN 2, LVN 2 was observed preparing medications for Resident 44. LVN 2 after preparing medications put on a pair of gloves and entered Resident 44's room to administer medications. LVN 2 was not observed washing hands or sanitizing hands with an alcohol-based hand sanitizer before putting on gloves and entering Resident 44's room and administered the medications. During an interview on 6/30/2026 at 8:53 AM, with LVN 2, LVN 2 stated that she put on gloves to touch a sticky bottle of LiguaCel (a protein supplement) and did not remove the gloves before entering the Resident 44's room and administering the medications. During an interview on 6/30/2026 at 2:36 PM with IP, IP stated licensed nurses must perform hand (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene before putting on gloves and after removal of gloves. IP stated licensed nurses must perform hand hygiene before entering a resident's room, and put on a new pair of gloves before resident contact. 1C. During a review of Resident 74's admission Record, the admission Record indicated Resident 74 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar), Hypertension (high blood pressure), Cataract (clouding of the eye's lens that makes it hard to see clearly), Intellectual Disabilities (significant limitations in learning, reasoning, and everyday skills), and Hearing Loss. During a review of Resident 74's Minimum Data Set (MDS, a resident assessment tool), dated 4/2/2026, the MDS indicated Resident 74 was moderate cognitive impairment. The MDS indicated Resident 74 was independent for eating, required supervision for oral hygiene and toileting, required partial assistance (Helper provides less than half the effort) for bathing, dressing, and personal hygiene. During a concurrent medication pass observation and interview on 6/30/2026 at 9:07 AM, with LVN 1, on Station A, Medication Cart 1, LVN 1 prepared medications for Resident 74 that included two eye drop medications: Artificial Tears (for dry eyes), and Prednisolone (for eye inflammation) one (1) percent (%). LVN 1, after preparing and administering oral medications to Resident 74, LVN 1 put on a pair of gloves without washing or sanitizing her hands. LVN 1 stated and was observed instilling one drip of Artificial Tears into each eye. During an interview on 6/30/2026 at 2:38 PM with IP, IP explained that while putting on gloves provides a barrier, it is not completely effective. IP stated that residue, sweat, and substances from handling medications can transfer onto the gloves and potentially reach the eye membrane. IP stated that hand hygiene must be performed before administering eye medications to prevent bacteria, organisms, or viruses from entering the eye. 1D. During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Attention to Gastrostomy (care for a feeding tube placed through the abdomen into the stomach to help deliver food or medicine), Dementia (a progressive brain disease that affects memory, thinking, and behavior), Type II Diabetes Mellitus (DM, a chronic disease that affects how the body processes sugar), Hypertension (high blood pressure), and Long Term (Current) use of Opiate Analgesic (a controlled medication used to relieve pain). During a review of Resident 63's history and physical (H&P) dated 12/20/2025, the H&P indicated Resident 63 did not have the capacity to understand and make decisions During a review of Resident 63's Minimum Data Set (MDS, a resident assessment tool), dated 5/12/2026, the MDS indicated Resident 63 was severely cognitively impaired. The MDS indicated Resident 63 was dependent (helper provides all of the effort) for all aspects of activities of daily living (ADLs, routine tasks/activities such as eating, oral and personal hygiene, toileting, bathing, dressing, and transfer, tasks a person performs daily to care for themselves). During a medication pass observation on 6/30/2026 between 9:35 AM to 10:13 AM, with LVN 1, on (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Station A, Medication Cart 1, LVN 1 after preparing medications for Resident 63, LVN 1 entered the resident's room without washing or sanitizing hands or putting on a gown. LVN 1, was observed checking Resident 63's blood pressure and checked the resident's G-tube placement and residual. LVN 1 was observed putting on a pair of gloves without washing or sanitizing her hands and administered Resident 63's medication via G-tube. During an interview on 6/30/2026 at 10:16 AM with LVN 1, LVN 1 stated that she should have sanitized her hands before putting on gloves each time. During an interview on 6/30/2026 at 3:08 PM, with LVN 1, LVN 1 acknowledged there was an Enhanced Barrier Precaution (EBP) sign outside of Resident 63's door. LVN 1 stated that she did not wear a gown or appropriate PPE when she administered medications via G-tube to Resident 63 and should have. During a review of the facility's policy and procedures (P&P) titled, Enhanced Barrier Precautions reviewed 3/2026, the P&P indicated Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.device care or use (central line, urinary catheter, feeding tube.) EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. EBPs remain in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that places them at increased risk.Staff are trained prior to caring for residents on EBPs. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. PPE is available outside of the resident rooms. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, reviewed 3/2026, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infection. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.Use an alcohol-based hand rub containing at least 62 % alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. Before and after direct contact with residents. Before preparing or handling medications. Before donning sterile gloves. Before moving from a contaminated body site to a clean body site during resident care. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident After removing gloves. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hand hygiene is the final step after removing and disposing of personal protective equipment. 2) During a review of Resident 70's admission Record (AR), the AR indicated the facility admitted Resident 70 on 11/30/2024 with diagnoses that included cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or partial paralysis on one side of the body) and dysphagia (difficulty swallowing). During a review of Resident 70's MDS dated [DATE], the MDS indicated Resident 70 had moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 70 used wheelchair. MDS indicated that Resident 70 was fully dependent on staff for eating and activities of daily living (ADL-oral hygiene, personal hygiene, sitting/laying, toileting hygiene, shower/bath, upper and lower body dressing, personal hygiene and toilet transfer). During a review of Resident 70's History and Physical (H&P &ndash; medical document which include resident's background, physical exam and assessment) by resident's physician and signed by the same physician, dated 6/2/2026, H&P indicated, The resident does not have the capacity for medical decisions due to: CVA. During a concurrent observation and interview on 07/01/2026 at 10:55 am with Certified Nursing Assistant (CNA) 1, CNA 1 observed to change Resident 70's pillowcase without using gloved or gown. Resident 70 was observed touching CNA 1's hands and clothing when CNA 1 placed the pillow back behind Resident 70's head after changing the pillowcase.[AD2.1][SS2.2][AD2.3] CNA 1 stated the Resident 70 was on EBP and staff need to use gloves and gown while providing care and touching the resident. During an interview on 07/01/2026 at 12:14 pm with IP, IP stated when providing care to the residents on EBP, staff need to put the gown and gloves, even mask in some cases. If a staff changes the pillowcase when resident is in bed, staff need to put gown and gloves for EBP residents. It can expose residents to bacteria or any other organisms. It can give them infection especially in open portal. During an interview on 07/01/2026 at 3:12 pm with DON, DON stated, (CNA 1) should have followed the transmission-based precautions. (CNA 1) should have been wearing gloves and gown when changing a pillowcase of a resident with EBP. There was a risk of transmission of infection in staff and residents. During a review of the facility's policy and procedures (P&P) titled, Infection Control dated 3/20/2026, the P&P indicated, The facilities infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. During a review of the facility's P&P titled, Enhanced Barrier Precautions dated 3/20/2026, the P&P indicated, EBPs employee targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high contact resident care activities requiring the use of gown and glove for EBP includes changing linens.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to protect the privacy and dignity of one of one sampled (Resident 42) when staff failed to ensure Resident 42's left hip and thigh were not exposed and completely covered in facility hallway while Resident 42 was being transported from the resident room to facility shower room according to the facility's policy and procedures (P&P) titled, Resident Rights, reviewed 3/20/2026. This deficient practice resulted in Resident 42 complaining of feeling bad, didn't like it, and felt exposed and had the potential to cause the resident to suffer psychosocial (mental, emotional, social, and spiritual effects) harm due to exposure of parts of resident's body to other residents and staff. Findings: During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted Resident 42 on 4/20/2023 with diagnoses that included major depression (Mood disorder that causes persistent sadness. And loss of interest in activities that a person used to enjoy), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis on one side of the body). During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool) dated 4/8/2026, the MDS indicated Resident 42 had no cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 42 used wheelchair. MDS indicated that Resident 42 need set up/clean up assistance for eating, partial assistance for oral hygiene, maximum activities of daily living (ADL- personal hygiene, sitting/laying, toileting hygiene and shower/bath) and fully dependent on staff for dressing, personal hygiene, sit/stand and toilet transfer. During a review of Resident 42's History and Physical (H&P - medical document which include resident's background, physical exam and assessment) dated 4/8/2026, H&P indicated Resident 42 had the capacity to make decisions for activity of daily living. During an observation on 6/30/2026 at 8:59 am, Resident 42 was observed in the hallway being pushed by Certified Nurse Assistant (CNA) 3 in a shower chair (a wheelchair that is used to transport resident safely to and from facility shower room and is water safe). Resident 42's right side and middle body and waist were covered with blanket. Resident 42's left thigh and buttocks were exposed and not covered with blanket or towel. During an interview on 6/30/2026 at 10:27 am, with Resident 42 in Resident's room, Resident 42 stated, I remember I was exposed on the side when someone was taking me for bath. I felt bad that I wasn't fully covered, I didn't like it. I felt exposed. During an interview on 6/30/2026 at 11:41 am, CNA 3 stated Resident 42's back and buttocks were exposed. CNA 3 stated Resident 42's left thigh and buttocks were not covered with blanket. CNA 3 stated, Resident 42 must have felt embarrassed. During an interview on 7/1/2026 at 3:12 pm, the Director of Nursing (DON) stated, Facility have to treat every single resident with dignity and respect. Any resident who is not fully covered in the hallway when taking resident to shower is not right. Resident would be feeling bad if exposed like that in the hallway. During a review of the facility's policy and procedures (P&P) titled, Resident Rights, reviewed 3/20/2026, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity.		

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. Based on observation, interview and record review, the facility failed to provide the June 2026 Activity Calendar, facility information, rules and regulations and weekly meal menu in a language one sampled resident (Resident 70) can read and understand. This failure resulted in Resident 70 inability to read and understand the June 2026 Activity Calendar, facility information, rules and regulations and weekly meal menu posted and had the potential for Resident 70 to not effectively communicate needs, understand care instructions, and participate in care planning. Findings: During a review of Resident 70's admission Record (AR), the AR indicated the facility admitted Resident 70 on 11/30/2024 with diagnoses that included cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness or partial paralysis on one side of the body) and dysphagia (difficulty swallowing). During a review of Resident 70's Minimum Data Set (MDS - a resident assessment tool) dated 6/24/2026, the MDS indicated Resident 70 had moderate cognitive (the mental ability to make decisions of daily living) impairment. The MDS indicated Resident 70 used wheelchair. The MDS indicated Resident 70 was fully dependent on staff for eating and activities of daily living (ADL-oral hygiene, personal hygiene, sitting/laying, toileting hygiene, shower/bath, upper and lower body dressing, personal hygiene and toilet transfer). During a review of Resident 70's History and Physical (H&P - medical document which include resident's background, physical exam and assessment) by resident's physician and signed by the same physician, dated 6/2/2026, the H&P indicated Resident 70 does not have the capacity for medical decisions due to CVA. During an observation and concurrent interview on 6/30/2026 at 9:48 am in Resident 70's room, the June 2026 Activity Calendar, facility information, rules and regulations and weekly meal menu posted on the wall in front of the resident's bed, were in English. During an interview on 6/30/2026 at 10:02 am with the Resident 70 (with an interpreter via phone) the help of interpreter, Resident 70 stated Resident 70 does not speak or read English. Resident 70 stated Resident 70 is unable to read the facility rules, regulations, activity calendar and weekly meal menu posted in resident's room. During an interview on 6/30/2026 at 2:51 pm with Licensed Vocational Nurse (LVN) 5, LVN 5 stated LVN 5 has always communicated with non-English speaking residents with the help of communication board (a small board used by facility staff and residents, with translation of most common words like eating, restroom and need help, into the language that resident can speak/read) and facility staff that speak the same language as the resident. LVN 5 stated LVN 5 doesn't know of any interpretation services that facility use. During an interview on 6/30/2026 at 3:07 pm with Certified Nursing Assistant (CNA) 2, CNA 2 stated the facility has some staff that speak Spanish and other languages. CNA 2 stated the facility staff always communicate with non - English speaking residents with the help of facility staff who speak the same language as the resident. CNA 2 stated it will be a difficult to communicate with a non - English speaking resident if facility don't have a staff member who can speak the same language as the resident. During an interview on 7/1/2026 at 10:55 pm with CNA 1, CNA 1 stated some of the facility staff speak Spanish and other languages. CNA 1 stated CNA 1 always translated for Resident 70 when CNA 1 is working in the facility. CNA 1 stated that communication with non-English speaking residents is challenging if no staff speaks the resident's language. CNA 1 stated CNA 1 does not know of any interpretation services the facility uses/offers. During an interview on 7/1/2026 at 3:16 pm with Director of Nursing (DON), DON stated facility staff need to use facility's interpreter services in order to communicate with the non-English speaking residents. DON stated, If a non-English speak resident (Resident 70) is not able to access to an interpreter to meet resident's needs, it will make (continued on next page)		

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 70 feel isolated. Resident 70 wouldn't know how to communicate, she will feel bad. She will feel very sad. During a review of the facility's policy and procedures (P&P) titled, Accommodation of needs related to communication deficits., reviewed 3/20/2026, indicated, Communication needs will be identified and appropriate interventions, including care planning, will be developed in order to accommodate the communication needs of the resident.		