STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555074	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road Mission Hills, CA 91345

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that each resident received care and services for the provision of parenteral fluids (formulated liquids that are injected into a vein) consistent with professional standards of practice for two of two sampled residents (Residents 50 and 2) by failing to: 1.a. Label Resident 50's Dextrose 5 percent (% - one part in every hundred) in Normal Saline (D5 NS, a sterile intravenous [IV - through the vein] solution used to replenish fluids, calories, and electrolytes) and document the administration per facility policy and procedures (P&P). 1.b. Label Resident 50's peripheral intravenous site with a date when it was inserted. 1.c. Ensure Resident 50's peripheral IV flush port (serves as an access to deliver saline or other medications to the vein) was covered with a disinfected cap (an alcohol containing caps that twist onto IV access points for disinfection and protection) 2.a. Label Resident 2's peripheral intravenous (IV - through the vein) site with a date when it was inserted. 2.b. Ensure Resident 2's peripheral IV flush port was covered with a disinfected cap. These deficient practices had the potential to result in parenteral fluids not being administered per physician's orders, mismanagement of resident's needs for fluid intake, and infections such as phlebitis (inflammation of a vein). Findings: 1. During a review of the facility's census (lists typically contain resident names, locations (unit/room), and the dates of admission), the facility's census indicated the facility originally admitted Resident 50 on 3/2/2026 and readmitted on [DATE]. During a review of Resident 50's History and Physical (H&P), dated 3/13/2026, the H&P indicated the resident had diagnoses including chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy (opening surgically created through the front of the neck and into the trachea [windpipe]), percutaneous endoscopic gastrostomy (PEG, GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement, and sepsis (a life-threatening blood infection). During a review of Resident 50's Minimum Data Set (MDS – a resident assessment tool), dated 3/4/2026, the MDS indicated the resident was rarely/never able to make himself understood and rarely/never able to understand others. The MDS indicated Resident 50 was dependent on staff for oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 50' s physician orders, the physician orders indicated an order for D5 NS continuous IV infusion at a rate of 75 milliliters (mL, a unit of measurement) per hour (mL/hr.), dated 3/22/2026. During a review of Resident 50's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), the MAR indicated the last documented administration of D5 NS was on 3/22/2026 at 2:12 p.m. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 50's care plan (CP) titled, Altered Urinary Elimination ., with start date of 3/24/2026, the CP indicated interventions that included to give fluids as ordered. During a concurrent observation and interview on 3/23/2026 at 9:39 a.m., observed Resident 50 lying in bed with Family Member (FM) 1 at bedside. FM 1 stated Resident 50 required IV fluids because the resident was not tolerating the enteral feeding (EF - also known as tube feeding [TF], a method of supplying nutrients directly into the stomach) and the TF was not being administered. Observed an IV pump (device used to administer IV medication) administering fluids from an unlabeled bag of D5 NS to Resident 50 at a rate of 75 mL/hr. Observed approximately 300 mL out of 1000 mL remained in the bag. During a concurrent observation and interview on 3/23/2026 at 10:47 a.m., at Resident 50's bedside with Registered Nurse (RN) 6, RN 6 stated D5 NS is considered a medication, and the D5 NS bag should be labeled with the resident's name, date, and flow rate of administration as part of the medication administration process. RN 6 stated it was important to label medication and fluids to ensure the correct fluids were administered to the correct person at the correct time and at the correct rate. RN 6 stated Resident 50's D5 NS fluid bag was not labeled, but it should have been. During an interview on 3/25/2026 at 8 a.m. with RN 1, RN 1 stated the facility process for labeling and administering D5 NS fluids from the facility stock is the bag of fluids is labeled for safe medication administration. RN 1 stated during the medication administration the LN checks the label against the physician's order to ensure the resident gets exactly what the physician ordered. RN 1 stated when the D5 NS was not labeled there was the potential to result in a medication error leading to resident harm. During a concurrent interview and record review on 3/27/2026 at 7 a.m. with the Clinical Educator (CE), the CE reviewed Resident 50's physician orders and MAR for 3/2026. The CE stated on 2/23/2026 Resident 50 was administered D5 NS via IV and there was no documented evidence that the LN who started the administration documented in the MAR. The CE stated she was not sure who administered the D5 NS to Resident 50, when the D5 NS began being administered, or how much D5 NS Resident 50 received because there was no documentation and the fluids were not labeled. During an interview on 3/27/2026 at 8:33 a.m. with RN 5, RN 5 stated she (RN 5) cared for Resident 50 on 2/23/2026. RN 5 stated she did not start the administration of Resident 50's D5 NS on 2/23/2026 because the fluids were already being administered when she arrived. RN 5 stated Resident 50's D5 NS was not labeled, and she was not sure who started the administration of the unlabeled bag. During a concurrent interview and record review on 3/26/2026 at 4 p.m. with RN 1, RN 1 reviewed the facility P&P for medication administration. RN 1 stated the facility P&P was not followed when Resident 50's D5 NS was not labeled or documented as administered on 3/23/2026 potentially resulting in a medication error. During a review of the facility provided P&P titled, Medication Administration and Monitoring (Sub Acute), effective date 3/2025, the P&P indicated, The Registered Nurses and Licensed Vocational Nurses are responsible for the accurate administration and documentation of medications. The purpose of this policy is to safely and accurately administer medications to residents by those authorized to do so as defined by their scope of practice. E. Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions/warnings of the medications being administered. MAR represents the official and real-time document for active medication orders .Always observe the seven-rights of medication administration: 1. the right drug 2. the right patient 3. the right time 4. the right dose of the drug 5. the right route 6. the right reason (indication) 7. the right documentation Medications are administered exactly as ordered. All medications are appropriately labeled. 5. Documentation and EMAR: A. Documentation is required for all medications administered . 8. Documentation is completed by the healthcare providers, who administer the medications . E. IV solutions are documented every time a new bag is hung and at every rate change. The nurse must select the appropriate action when documenting IV infusion. Examples of action include: 1. New Bag 2. Rate/Dose change 3. Rate/Dose verify 4. Restarted 5. Stopped . 2. During a review of the facility's census, the facility's census indicated the facility originally admitted Resident 2 on 10/29/2024 and readmitted on [DATE]. During a review of Resident 2's H&P, dated 1/7/2026, the H&P indicated the resident with diagnoses including gunshot wound on abdomen, multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident had no speech, rarely/never makes self understood, rarely/never had the ability to understand others, and had severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. During a review of Resident 2' s Active Orders (AO), dated 1/25/2026, the AO indicated an order to insert one peripheral IV one time with process instructions May use venipuncture analgesia per (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility protocol. Flush line per standard of care. During a review of Resident 2's CP titled, Adult Inpatient Plan of Care, start date 12/17/2025, the CP indicated the resident with goals of absence of hospital-acquired illness or injury with interventions to prevent infection including identify potential sources of infection early to prevent or mitigate progression of infection (e.g., wound, lines, devices) and evaluate ongoing need for invasive devices; remove promptly when no longer indicated. During an observation on 3/23/2026 at 9:52 a.m., at Resident 2's bedside, Resident 2 with peripheral IV on left forearm wrapped with gauze dressing. During a concurrent observation and interview on 3/23/2026 at 11:10 a.m., at Resident 2's bedside with RN 5, RN 5 stated Resident 2 has a left forearm peripheral IV with no label of date of insertion and the peripheral flush port with no green disinfecting cap. RN 5 stated it should have a date of insertion , so they know when it needs to be changed and the flush port covered with a green disinfecting cap. During an interview on 3/27/2026 at 11:03 a.m. with the CE, the CE stated that once the peripheral IV line is inserted the licensed nurse labels the dressing with a date of when it was inserted. The CE stated this provides visible information that helps with the nursing assessments and following their protocol of IV dressing changes. The CE stated when IV dressing does not have a date of insertion this could place the resident at risk of infection and complication. The CE stated for peripheral IV they use of Curos caps (disinfecting caps) and they leave the cap to prevent any foreign bodies or bacterial build-up in the PIV line. The CE stated when this is not done the resident is at risk for infection. During a review of the facility's P&P titled, Comprehensive Vascular Access Management, last revised and approved on 5/2023, the P&P indicated M. Passive Disinfection Cap – A cap containing a disinfectant agent (isopropyl alcohol) that is placed on the access point in between intermittent infusions or medication administration to reduce intraluminal microbial contamination and minimize surface contamination. N. Peripheral Intravenous Catheter (PIV) – Short intravenous catheter inserted in a peripheral vein. Length of catheter ranges from 3 to 6 cm. PERIPHERAL AND MIDLINE MAINTENANCE. 5. The dressing will be labeled, indicating the date of insertion. 9. Place a passive disinfection cap, when available by ministry, to all access ports or needless connector in between intermittent infusions or medication administration. If the disinfection cap is removed, the used cap is discarded and is not reattached to the needleless connector

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure to store, prepare, and serve food in accordance with professional standards of practice for food service safety by failing to: 1. Dispose green bell peppers pre-cut on its discard date (date out). 2. Dispose burger patties on its discard date. 3. Dispose chopped green onions discard date. 4. Label diced carrots with date in (when a product was prepared, opened, or received) and date out (discard date). 5. Cover and label with date in and date out three (3) cups of water in the Sub-Acute (for residents needing services that are more intensive than those typically received in skilled nursing facilities [SNF] but less intensive than acute care) pantry freezer. These deficient practices had the potential to cause food-borne illnesses (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in six of 46 medically compromised residents who received food from the kitchen. Findings: During a concurrent observation and interview on 3/23/2026 at 8:12 a.m., with Food and Nutrition Dietary Supervisor (FNDS) 1, inside the kitchen, observed the following: - vegetable precut of green bell peppers with good thru 3/20/2026; - chopped green onion with date out 3/21/2026; - diced carrots with no label of date it was date in and date out; - burger patties date in 3/18/2026 and date out 3/22/2026. FNDS 1 stated these should have been disposed of. FNDS 1 stated good thru and date out is the discard date. The FNDS 1 stated the diced carrots should have a label of date in and date out it is their policy for food safety. During a concurrent observation and interview on 3/23/2026 at 8:39 a.m., with FNDS 1, inside the Sub-Acute pantry, observed 3 cups of water in the freezer uncovered and no label of date in and date out. FNDS 1 stated in the freezer there are three cups of water in a disposable cup and should have a cover/lid and labeled with a date. FNDS 1 stated it should be covered to prevent contaminants from going in, anything can go inside the water and date to know how long it has been stored. FNDS 1 stated he will dispose of the 3 cups. During an interview on 3/27/2026 at 10:18 a.m., with the Director of Food and Nutrition Services (DFNS), the DFNS stated the date out would be the expiration date and beyond that should be discarded. The DFNS stated the items are labeled with a date in when it was thawed, opened, or prepared. The DFNS stated this is to provide safe food to their residents and not serve foods that has spoiled beyond the expiration date. The DFNS stated their facility follows a tighter schedule of 3 days shelf-life and they have to follow what their policy says. The DFNS stated that when the policy is not followed the residents can become more ill depending on their illness and their immune system, they can develop an intestinal issue and can be severe. During a review of the facility's policy and procedure (P&P) titled, Food and Supply Storage, revised 1/2025, the P&P indicated that All food, non-food items and supplies used in food preparation shall be stored in a manner as to prevent contamination to maintain the safety and wholesomeness of the food and human consumption. Most, but not all, products contain expiration date:. Foods past the use-by, sell-by, best-by:, or enjoy by date should be discarded. Cover, label, and date unused portions and open packages. Products are good through the close of business on the date noted on the label.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a person-centered care plan (tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for aspiration precautions for one of two sampled residents (Resident 39) reviewed for tube feeding (TF - a method of supplying nutrients directly into the stomach). This deficient practice had the potential to place Resident 39 at risk for respiratory infections such as pneumonia (an infection/inflammation in the lungs). Cross-reference F693. Findings: During a review of Resident 39's History and Physical (H&P), dated 7/26/2025, the H&P indicated that the resident was admitted on [DATE] with diagnoses including sepsis (a life-threatening blood infection), ventilator (a medical device to help support or replace breathing) associated pneumonia, and percutaneous endoscopic gastrostomy status (a feeding tube placed directly into the stomach through the abdominal wall to provide long-term nutrition). During a review of Resident 39's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated that the facility originally admitted the resident on 11/22/2022 and readmitted the resident on 7/30/2025. The MDS indicated Resident 39 was comatose (of, resembling, or affected with coma), dependent with rolling left and right while on the bed and has a feeding tube while a resident of this facility. During a review of Resident 39's physician order, dated 7/30/2025, the physician order indicated aspiration precautions to implement precautions per department/hospital protocol. During an observation on 3/23/2026 at 9:43 a.m., inside Resident 39's room, observed Resident 39 lying in bed with the TF pump turned on and administering TF. Observed the digital angle display screen on the bed indicated 26 degrees. Observed no staff were present in the room. During a concurrent observation and interview on 3/23/2026 at 10:17 a.m., with Certified Nursing Assistant (CNA) 1, inside Resident 39's room, CNA 1 stated Resident 39's digital bed angle indicated at 26 degrees. CNA 1 stated he did not know how long Resident 39 had been lying at 26 degrees bed angle. CNA 1 stated he will adjust it to 30 degrees. CNA 1 stated it should be 30 degrees or more. During a concurrent interview and record review on 3/27/2026 at 9:36 a.m., with the MDS Coordinator (MDSC), reviewed Resident 39's Care Plans (CP), the MDSC stated there was no care plan developed for aspiration precautions. The MDSC stated it should have been added when Resident 39 was readmitted on [DATE]. The MDSC stated the goal of aspiration precautions care plan is to prevent the resident from developing respiratory infections such as pneumonia related to TF and lying prone at risk for aspiration. The MDSC stated the interventions would include head of bed elevated at least 30 degrees to prevent aspiration. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding, last revised 6/2023, the P&P indicated, The purpose of this policy is to. 1. Provide nourishment to patients who are unable to meet their nutritional needs orally. Enteral formula administration and handling guidelines are found in Lippincott procedures for nursing to follow for tube feeding administration. During a review of the facility's P&P titled, Enteral tube feeding, continuous, gastrostomy and jejunostomy, last revised 12/15/2025, the Procedure indicated, Procedure for . Pump Use. Implementation. Position the patient with the head of the bed elevated to at least 30 degrees or seated upright in a chair, unless contraindicated, to prevent aspiration. During a review of the facility's P&P titled, Standards of Sub Acute, last revised and approved 10/2025, the P&P indicated the purpose of this P&P is To conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident in the Sub-Acute Unit. Procedures/General Instructions - Sub-Acute Unit Assessment:. 7. MDS, Care Area Assessment (CAA) and care plan will be completed within 14 days and amended within 21 days of admission.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazards and adequate supervision and assistance to prevent falls and injury for one of two sampled residents (Resident 7) reviewed during the Accidents care area by failing to ensure the bed was maintained in the lowest position while the resident was left unattended. This deficient practice had the potential to result in falls leading to injury. Findings: During a review of Resident 7's History and Physical (H&P), dated 10/27/2025, the H&P indicated the resident was most recently admitted to the facility on [DATE] with diagnoses that included status epilepticus (a seizure disorder [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] lasting longer than five [5] minutes) chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheotomy (opening surgically created through the front of the neck and into the trachea [windpipe]), and percutaneous endoscopic gastrostomy (PEG, GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2026, the MDS indicated the resident was originally admitted to the facility on [DATE]. The MDS further indicated the resident rarely / never had the ability to make herself understood or understand others. The MDS indicated the resident was dependent on staff for oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 7's Physician's Orders, dated 10/26/2025, the physician's orders indicated the following: - Implement fall precautions per department protocol. During a review of Resident 7's Fall Risk Assessment, dated 3/23/2026, the Fall Risk Assessment indicated Resident 7 was a high risk for falls. During a review of Resident 7's Care Plan (CP) titled, Fall injury Risk, started 10/28/2026, the CP indicated a goal that the resident would be free of falls and fall related injuries with interventions that included to develop a fall prevention program, considering resident-centered interventions and to identify and address resident's barriers. During a review of Resident 7's Care Plan (CP) titled, Seizure, Active Management (adult), started 10/27/2026, the CP indicated a goal that the resident would have an absence of seizure and seizure related injury with interventions that included to maintain seizure precautions such as the bed in the low position. During an observation on 3/23/2026 at 10:22 a.m., inside Resident 7's room, observed the resident lying in bed. Observed the bed was elevated to the high position. Observed a flashing amber light projecting a bed symbol onto the floor. During a concurrent observation and interview on 3/23/2026 at 10:37 a.m., with Registered Nurse (RN) 6, RN 6 stated Resident 7's bed was flashing an amber light onto the ground, but she did not know why. RN 6 stated she would have to check why the light was flashing. Observed RN 6 exit Resident 7's room with the bed left in the high position. During a concurrent observation and interview on 3/23/2026 at 11:07 a.m. with RN 6, observed RN 6 return to Resident 7's room. Observed Resident 7's bed remain in the high position. RN 6 stated Resident 7's bed looked high. RN 6 stated most residents should not have the bed in the high position. Observed RN 6 lowered Resident 7's bed. Observed when the bed was lowered to the lowest position the amber flashing light turned to solid green. RN 6 stated Resident 7's flashing amber bed light indicated the bed was elevated. RN 6 stated Resident 7 was a high risk for falls and the bed should have been lowered to the lowest position, but it was not. RN 6 stated when Resident 7 was left unattended with the bed in the high position there was the potential for a gravity fall resulting in broken bones or worse. During a concurrent interview and record review on 3/24/2026 at 2:52 a.m. with the Director of Nursing (DON) and the Clinical Educator (CE), the manufacturer's instructions for Bed 1 was reviewed. The CE stated when Bed 1 flashed an amber light with a bed symbol it indicated the bed was not in the low position. The CE stated the light flashes to get staff attention to lower the bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated Resident 7's has a history of seizures and the bed should always be in the lowest position to prevent falls from a higher position that can potentially worsen the severity of injuries. During a concurrent interview and record review on 3/26/2026 at 4 p.m. with RN 1, the facility's policy and procedures (P&P) regarding fall prevention was reviewed. RN 1 stated the facility P&P regarding fall prevention indicates to implement interventions to prevent falls. RN 1 stated the P&P was not followed when Resident 7 was left unattended with the bed in the high position potentially resulting in the resident having a seizure and falling from the bed leading to injuries. During a review of the facility's provided P&P titled, Fall Risk Prevention (Sub Acute), last revised 12/2025, the P&P indicated, In keeping with the mission and values . it is the policy . to provide excellent patient/resident care and follow the principles to reduce the incidence of preventable falls and the risk of patient injury from a fall. Implement the following resident specific fall prevention strategies based on the resident's fall risk score . Bed in low position.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receiving enteral feeding (EF - also known as tube feeding [TF], a method of supplying nutrients directly into the stomach) received appropriate care and services to prevent complications by failing to ensure the head of the bed (HOB) was elevated to greater than 30 degrees (a unit of angle measurement) per facility policy and procedures (P&P) for two of two sampled residents (Resident 7 and 39) reviewed for TF. This deficient practice placed Residents 7 and 39 at increased risk for complications of aspiration (when food or liquid enters the airway and lungs instead of the stomach) including aspiration pneumonia (an infection/inflammation in the lungs). Findings: a. During a review of Resident 7's History and Physical (H&P), dated 10/27/2025, the H&P indicated the resident was most recently admitted to the facility on [DATE] with diagnoses that included status epilepticus (a seizure [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] lasting longer than 5 minutes) chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheotomy (opening surgically created through the front of the neck and into the trachea [windpipe]), percutaneous endoscopic gastrostomy (PEG, GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement, and aspiration pneumonia. The H&P indicated the resident ate nothing by mouth. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 1/30/2026, the MDS indicated the resident was originally admitted to the facility on [DATE]. The MDS further indicated the resident rarely / never had the ability to make herself understood or understand others. The MDS indicated the resident was dependent on staff for oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 7's Physician's Orders, the physician's orders indicated the following: - Implement aspiration precautions per department protocol, dated 10/26/2025. - Continuous TF with TF Formula (TFF) 1 at a rate of 70 milliliters (mL, a unit of measurement) per hour (mL/hr.), until discontinued, dated 11/3/2025. During a review of Resident 7's Care Plan (CP) titled, Enteral Nutrition,, started 10/27/2026, the CP indicated a goal that the resident would be free from aspiration signs and symptoms with interventions that included to elevate the HOB to a semi recumbent position (a therapeutic, reclined posture where a resident lies on their back with the head of the bed elevated between 30 degrees [degrees] and 45 degrees) During an observation on 3/23/2026 at 10:22 a.m., inside Resident 7's room, observed the resident lying in bed with the TF pump (device that delivers TF) turned on and administering the TF. Observed the digital angle display screen on the bed indicated 26 degrees . Observed no staff were present in the room. During a concurrent observation and interview on 3/23/2026 at 10:37 a.m., with RN 6, observed RN 6 entered Resident 7's room. RN 6 stated when a resident is being administered TF, the HOB should be elevated to 30 degrees to prevent aspiration potentially leading to pneumonia. RN 6 stated all staff (continued on next page)

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	555074	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Holy Cross Med Ctr D/P Snf	11600a Indian Hills Road Mission Hills, CA 91345

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	members are responsible for ensuring the HOB is at 30 degrees and there is a screen on the bed that indicates the degree of the angle. RN 6 stated the screen on Resident 7's bed indicated the HOB was elevated to 26 degrees . RN 6 stated Resident 7's HOB needed to be elevated more, and it was not. During a concurrent interview and record review on 3/26/2026 at 4 p.m. with RN 1, RN 1 reviewed the facility policy and procedures (P&P) regarding TF. RN 1 stated residents on continuous TF should not be lying flat because the TF may go into their lungs resulting in complications like aspiration pneumonia. RN 1 stated the facility P&P indicates residents on TF should have the HOB elevated to 30 degrees. RN 1 stated the P&P was not followed when Resident 7's HOB was elevated to 26 degrees. b. During a review of Resident 39's H&P, dated 7/26/2025, the H&P indicated that the resident was admitted on [DATE] with diagnoses including sepsis (a life-threatening blood infection), ventilator (a medical device to help support or replace breathing) associated pneumonia (an infection/inflammation in the lungs), and percutaneous endoscopic gastrostomy status (a feeding tube placed directly into the stomach through the abdominal wall to provide long-term nutrition). During a review of Resident 39's MDS, dated [DATE], the MDS indicated that the facility originally admitted the resident on 11/22/2022 and readmitted the resident on 7/30/2025. The MDS indicated the resident was comatose (of, resembling, or affected with coma), dependent with rolling left and right while on the bed and has a feeding tube while a resident of this facility. During a review of Resident 39's physician order, dated 7/30/2025, the physician order indicated aspiration precautions to implement precautions per department/hospital protocol. During an observation on 3/23/2026 at 9:43 a.m., inside Resident 39's room, observed Resident 39 lying in bed with the TF pump turned on and administering TF. Observed the digital angle display screen on the bed indicated 26 degrees. Observed no staff were present in the room. During a concurrent observation and interview on 3/23/2026 at 10:17 a.m., with Certified Nursing Assistant (CNA) 1, inside Resident 39's room, CNA 1 stated Resident 39's digital bed angle indicated at 26 degrees. CNA 1 stated he does not know how long Resident 39 had been lying at 26 degrees bed angle. CNA 1 stated he will adjust it to 30 degrees. CNA 1 stated it should be 30 degrees or more. During a concurrent interview and record review on 3/27/2026 at 9:36 a.m., with the MDS Coordinator (MDSC), reviewed Resident 39's Care Plans (CP), the MDSC stated there was no care plan developed for aspiration precautions. The MDSC stated it should have been added when Resident 39 was readmitted on [DATE]. The MDSC stated the goal of aspiration precautions care plan is to prevent the resident from developing respiratory infections such as pneumonia related to TF and lying prone at risk for aspiration. The MDSC stated the interventions would include head of bed elevated at least 30 degrees to prevent aspiration. During a review of the facility provided P&P titled, Enteral Feeding, last revised 6/2023, the P&P indicated, The purpose of this policy is to. 1. Provide nourishment to patients who are unable to meet their nutritional needs orally. Enteral formula administration and handling guidelines are found in Lippincott procedures for nursing to follow for tube feeding administration. During a review of the facility provided Procedure titled, Enteral tube feeding, continuous, gastrostomy and jejunostomy, last revised 12/15/2025, the Procedure indicated, Procedure for . Pump (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Use. Implementation. Position the patient with the head of the bed elevated to at least 30 degrees or seated upright in a chair, unless contraindicated, to prevent aspiration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to provide respiratory care consistent with professional standards of practice for one of one sampled resident (Resident 2) reviewed for respiratory care by failing to ensure Resident 2's bubble humidifier, dated 3/12/2026, was changed every three days per facility policy and procedure (P&P). This deficient practice placed Resident 2 at risk for acquiring respiratory infections. Findings: During a review of Resident 2's History and Physical (H&P), dated 1/7/2026, the H&P indicated that the facility admitted the resident on 12/16/2025 resident with diagnoses including gunshot wound on abdomen, multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2026, the MDS indicated the resident had no speech, rarely/never makes self understood, rarely/never had the ability to understand others, and had severely impaired (never/rarely made decisions) cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated that oxygen therapy (a treatment that provides extra oxygen to breathe in) was performed while a resident of the facility. During a review of Resident 2's Care Plan (CP) titled, Mechanical Ventilation Invasive (Adult), dated 12/17/2025, the CP indicated the resident with goals of optimal device function with interventions which included facilitate regular mechanical ventilator and proper humidification equipment checks to ensure proper function. Provide humidification. regularly replace closed suction equipment, perform ongoing device and stoma care to prevent infection. During a concurrent observation and interview on 3/23/2026 at 11:10 a.m., with Registered Nurse (RN) 5, inside Resident 2's room, RN 5 stated Resident 2 receives oxygen therapy, and the bubble humidifier was dated 3/12/2026. RN 5 stated the bubble humidifier is changed every 3 days or sooner if it is less than 25 per hundred (%). RN 5 stated she will change it.^ During a concurrent interview and record review on 3/27/2026 at 7:01 a.m., with Respiratory Therapist (RT) 1, reviewed Resident 2's respiratory daily charting, RT 1 stated oxygen tubing and bubble humidifier is changed every Wednesdays. Reviewed Resident 2's respiratory daily documentation from 3/17/2026 to 3/27/2026, RT 1 stated there was no documentation oxygen tubing and bubble humidifier was last changed. During an interview on 3/27/2026 at 10 a.m., with the Clinical Educator (CE), the CE stated oxygen therapy equipment is scheduled to be changed to avoid complications and place the resident at risk for respiratory illness such as pneumonia. During a review of the facility's P&P titled, Supply Change & Equipment Check Schedule, last approved 10/6/2025, the P&P indicated that the Bubble Humidifier is changed during the day when water level is at 25% or every 3 days.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one of three sampled residents (Resident 7) reviewed under the urinary tract infection (UTI - an infection in the bladder/urinary tract) care area by failing to ensure intravenous (IV - administered within a vein) piperacillin-tazobactam (also known as Zosyn, an antibiotic [medication used to treat bacterial infections]) was administered per the physician's ordered flow rate (the speed at which IV fluids or medications are delivered to a resident) and time schedule. This deficient practice resulted in medication infused at the wrong flow rate and late administration time potentially resulting in adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) including worsening UTI. Cross-reference F761. Findings: During a review of Resident 7's History and Physical (H&P), dated 10/27/2025, the H&P indicated the resident was most recently admitted to the facility on [DATE] with diagnoses that included status epilepticus (seizure disorder [a sudden, uncontrolled electrical disturbance in the brain which can cause jerking, blank stares, and loss of consciousness] lasting longer than five [5] minutes) chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheotomy (opening surgically created through the front of the neck and into the trachea [windpipe]), and percutaneous endoscopic gastrostomy (PEG, GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement. During a review of Resident 7's Minimum Data Set (MDS - a resident assessment tool), dated 1/30/2026, the MDS indicated the resident was originally admitted to the facility on [DATE]. The MDS further indicated the resident rarely / never had the ability to make herself understood or understand others. The MDS indicated the resident was dependent on staff for oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 7's Care Plan (CP) titled, Infection, started 10/23/2026, the CP indicated on 3/22/2026 the resident had a fever of 101.1 degrees (a unit of measurement). The CP indicated a goal that the resident would have an absence of signs and symptoms of infection with interventions that included to administer ordered antimicrobial (antibiotic) therapy promptly. During a review of Resident 7's Physician's Orders, dated 3/23/2026 and timed at 7:13 a.m., the physician's orders indicated the following: - Piperacillin-tazobactam 4.5 grams (g - a unit of measurement) in 50 milliliters (mL - a unit of liquid measurement) sodium chloride 0.9 percent (a sterile solution in which medication is mixed), give 4.5 g intravenously (IV -fluids or medications given directly into the blood stream) at a flow rate of 100 mL per hour (mL/hr.), one time bolus (a single, relatively large dose of a drug administered over a short period to quickly achieve therapeutic levels) over thirty minutes followed in four hours by maintenance dosing for urinary tract infection (UTI). During a review of Resident 7's Medication form for piperacillin-tazobactam, dated 3/25/2026, the Medication form indicated administration details that on 3/23/2026 at 8:16 a.m., Registered Nurse (RN) 6 administered the first dose of piperacillin-tazobactam taken from the emergency kit (E-kit - a secure, portable container that stores specific medications that are used to treat residents in emergencies) followed by the maintenance dose on 3/23/2026 at 5 p.m. During an observation on 3/23/2026 at 10:22 a.m., inside Resident 7's room, observed the resident lying in bed with an IV pump (device used to administer IV medication) running at 21.3 mL/hr. Observed attached to the pump an IV bag with a hand-written label that indicated Zosyn4.5 g and a start date and time of 3/23/2026 at 8:14 a.m. Observed approximately half of the medication solution remained in the IV bag. Observed the IV bag did not indicate the flow rate. During an interview on 3/23/2026 at 10:37 a.m. with RN 6, RN 6 stated Resident 7 had and infection and she (RN 6) received an order to administer Zosyn RN 6 stated she removed the first dose of Zosyn from the E-kit, mixed the medication with the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	solution, labeled the IV bag, set up the IV pump to administer the medication at a rate of 21.3 mL/hr, and began the medication administration at 8:14 a.m. RN 6 stated all medications need to be labeled per the physician's order with the resident's name, medication, dosage, route, and date and time of administration. RN 6 stated the flow rate for IV medication is part of the physician's order and should be indicated on the label as well, but it was not. RN 6 stated it was important to label the medication with the flow rate to ensure the medication is administered per the physicians ordered rate. RN 6 stated when medication is not administered at the ordered rate it could cause adverse effects for the resident. RN 6 stated Resident 7's Zosyn flow rate of 21.3 mL/hr was determined from the pre-programmed settings she selected from the IV pump. RN 6 stated the flow rate should be determined by the physician's order and not the IV pump settings to ensure the medication is administered at the rate determined by the physician. During an interview on 3/25/2026 at 7:50 a.m. with the Director of Nursing (DON), the DON stated medication pulled from the E-kit is labeled by the licensed nurse (LN) to complete the five rights of medication administration (fundamental nursing principle designed to prevent medication errors that includes ensuring the correct person receives the right medication in the proper amount, method, and schedule). The DON stated when medication is administered the LN compares the physician's order with the medication label. The DON stated the rate of flow is indicated in the order and the first dose of Zosyn was to be given as a bolus over half an hour. During an interview on 3/25/2026 at 8 a.m. with RN 1, RN 1 stated the facility process for labeling and administering medication from the E-kit is the LN refers to the physician's order or contacts the pharmacy to determine the flow rate. RN 1 stated the LN does not rely on the IV pump's preprogrammed settings to determine the flow rate. RN 1 stated the flow rate should be indicated on the medication label to ensure that the medication is administered per the physician's orders. RN 1 stated when the label does not indicate the flow rate there is the potential that the LN would not check the flow rate during the medication administration process resulting in the wrong rate of administration potentially leading to resident harm. During a follow-up concurrent interview and record review on 3/25/2026 at 10:59 a.m. with RN 1, Resident 7's Medication form for piperacillin-tazobactam, dated 3/25/2026, and surveyor provided photo, dated 3/23/2026 at 10:32 a.m., were reviewed. RN 1 stated Resident 7's physician ordered an initial bolus dose of Zosyn to be given over half an hour at approximately 8 a.m., followed by the maintenance dose four hours later at approximately 12 p.m. RN 1 stated on 3/23/2026, RN 6 administered Resident 7's initial dose of Zosyn at 8:13 a.m. at the wrong flow rate. RN 1 stated Resident 7 received Zosyn over four hours instead of a half an hour. RN 1 stated because of this, the second dose of Zosyn was not administered until 5 p.m. on 3/23/2026. RN 1 stated the second dose of Zosyn was administered four hours late. RN 1 stated it was considered a medication error when RN 6 did not administer Zosyn per the physician's orders when the flow rate and timing of the medication was wrong. During a follow-up interview on 3/25/2026 at 11:14 a.m. with RN 6, RN 6 stated on 3/23/2026 at around 8 a.m. she (RN 6) set Resident 7's IV pump to the wrong flow rate to administer Zosyn over four hours instead of per the physician's order of half an hour. RN 6 stated Resident 7's second dose of Zosyn was administered late. RN 6 stated it was a medication error that resulted in a delay of treatment, potentially resulting in the resident not receiving the medication quickly enough leading to a worsening of the resident's infection. During a concurrent interview and record review on 3/26/2026 at 4 p.m. with RN 1, RN 1 reviewed the facility's policy and procedures (P&P) regarding medication administration and labeling. RN 1 stated the P&P indicates medications are to be labeled and administered per the physician's orders. RN 1 stated the P&P was not followed when RN 6 did not label and administer Resident 7's Zosyn per the physician's orders resulting in a significant medication error that was reported and led to a delay in the resident's treatment for a UTI. During a review of the facility provided P&P titled, Admixing Medications, last revised 1/2025, the P&P indicated, A. The appropriate diluent is to be used when admixing medications. B. Admixed IV solutions must have a completed medication added label attached. IV. Procedure: A. Verify physician order. L. Label IV solution container with medication (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	added label, to include the following: . 5. Route and rate . 6. Directions for administration. During a review of the facility provided P&P titled, Medication Administration and Monitoring (Sub Acute), effective date 3/2025, the P&P indicated, The Registered Nurses and Licensed Vocational Nurses are responsible for the accurate administration and documentation of medications. The purpose of this policy is to safely and accurately administer medications to residents by those authorized to do so as defined by their scope of practice. D. All medication orders are reviewed by a pharmacist prior to administration to a resident unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication; or in urgent situations, when the resulting delay would harm the resident, including situations in which the resident experiences a sudden change in clinical status. E. Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and precautions/warnings of the medications being administered. Medications are administered exactly as ordered. All medications are appropriately labeled. During a review of the facility provided P&P titled, Medication Error Reporting, last revised 6/2025, the P&P indicated, DEFINITIONS: A. Medication error/event: any preventable event (actual/potential) that may cause or lead to inappropriate medication use and/or patient harm while the medication is in control of the healthcare professional, patient, or consumer. 1. Medication errors can occur within any of the following steps in the medication management process: . h. Administration.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services by failing to ensure: 1. Drugs were labeled in accordance with currently accepted professional principles to facilitate consideration of precautions and safe administration of medications by failing to ensure intravenous (IV, administered within a vein) piperacillin-tazobactam (an antibiotic [medication used to treat bacterial infections)] was labeled with the flow rate (the speed at which IV fluids or medications are delivered to a resident) for one of three sampled residents (Resident 7) reviewed under the urinary tract infection (UTI- an infection in the bladder/urinary tract) care area. This deficient practice had the potential to result in medication administration infused at the wrong rate resulting in adverse effects (an undesired and harmful result of a treatment or intervention, such as a medication or surgery) including worsening UTI. 2. Humulin R (insulin regular - a short-acting human insulin used to control high blood sugar) was discarded when it was past its 31-day storage in one of three medication cart (Med Cart 1) for Resident 5 reviewed under Medication Storage and Labeling task. This deficient practice had the potential to result in the medication to be administered to the resident possibly resulting in ineffective blood sugar control. Findings: a. During a review of Resident 7's History and Physical (H&P), dated 10/27/2025, the H&P indicated the resident was most recently admitted to the facility on [DATE] with diagnoses that included status epilepticus (seizure disorder [a sudden, uncontrolled electrical disturbance in the brain which can cause jerking, blank stares, and loss of consciousness] lasting longer than 5 minutes) chronic respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheotomy (opening surgically created through the front of the neck and into the trachea [windpipe]), and percutaneous endoscopic gastrostomy (PEG, GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 1/30/2026, the MDS indicated the resident was originally admitted to the facility on [DATE]. The MDS further indicated Resident 7 rarely / never had the ability to make herself understood or understand others. The MDS indicated Resident 7 was dependent on staff for oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 7's Care Plan (CP) titled, Infection, started 10/23/2026, the CP indicated on 3/22/2026 the resident had a fever of 101.1 degrees (a unit of measurement). The CP indicated a goal that Resident 7 would have an absence of signs and symptoms of infection with interventions that included to administer ordered antimicrobial (antibiotic) therapy promptly. During a review of Resident 7's Physician's Orders, the physician's orders indicated the following: - Piperacillin-tazobactam 4.5 grams (g, a unit of measurement) in 50 milliliters (mL, a unit of liquid measurement) sodium chloride 0.9 percent (a sterile solution in which medication is mixed), give 4.5 g intravenously (IV -fluids or medications given directly into the blood stream) at a flow rate of 100 mL per hour (mL/hr.), one time bolus (a single, relatively large dose of a drug administered over a short period to quickly achieve therapeutic levels) over thirty minutes followed in four hours by maintenance dosing for urinary tract infection (UTI), dated 3/23/2026 at 7:13 a.m. During a review of Resident 7's Medication form for piperacillin-tazobactam, dated 3/25/2026, the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication form indicated administration details that on 3/23/2026 at 8:16 a.m. Registered Nurse (RN) 6 administered the first dose of piperacillin-tazobactam taken from the emergency kit (E-kit – a secure, portable container that stores specific medications that are used to treat patients in emergencies) followed by the maintenance dose on 3/23/2026 at 5 p.m. During an observation on 3/23/2026 at 10:22 a.m., inside Resident 7's room, observed the resident lying in bed with an IV pump (device used to administer IV medication) running at 21.3 mL/hr. Observed attached to the pump an IV bag with a hand-written label that indicated Zosyn ™ (brand name for piperacillin-tazobactam) 4.5 g and a start date and time of 3/23/2026 at 8:14 a.m. Observed approximately half of the medication solution remained in the IV bag. Observed the IV bag did not indicate the flow rate. During a concurrent observation and interview on 3/23/2026 at 10:37 a.m., with RN 6, RN 6 stated Resident 7 had and infection and she (RN 6) received an order to administer Zosyn™. RN 6 stated she removed the first dose of Zosyn™ from the E-kit, mixed the medication with the solution, labeled the IV bag, set up the IV pump to administer the medication at a rate of 21.3 mL/hr, and began the medication administration at 8:14 a.m. RN 6 stated all medications need to be labeled per the physician's order with the resident's name, medication, dosage, route, and date and time of administration. RN 6 stated the flow rate for IV medication is part of the physician's order and should be indicated on the label as well, but it was not. RN 6 stated it was important to label the medication with the flow rate to ensure the medication is administered per the physicians ordered rate. RN 6 stated when medication is not administered at the ordered rate it could cause adverse effects for the resident like fluid overload (too much fluid in the body causing swelling). During an interview on 3/25/2026 at 7:50 a.m. with the Director of Nursing (DON), the DON stated medication pulled from the E-kit is labeled by the licensed nurse (LN) to complete the five rights of medication administration (fundamental nursing principle designed to prevent medication errors that includes ensuring the correct person receives the right medication in the proper amount, method, and schedule). The DON stated when medication is administered the LN compares the physician's order with the medication label. During an interview on 3/25/2026 at 8 a.m. with RN 1, RN 1 stated the facility process for labeling and administering medication from the E-kit is the LN refers to the physician's order or contacts the pharmacy to determine the flow rate. RN 1 stated the flow rate should be indicated on the medication label to ensure that the medication is administered per the physician's orders. RN 1 stated when the label does not indicate the flow rate there is the potential that the LN would not check the flow rate during the medication administration process resulting in the wrong rate of administration potentially leading to resident harm. During a concurrent interview and record review on 3/26/2026 at 4 p.m. with RN 1, RN 1 reviewed the facility policy and procedures (P&P) regarding medication administration and labeling. RN 1 stated the P&P indicates medications are to be labeled and administered per the physician's orders. RN 1 stated the P&P was not followed when RN 6 did not label Resident 7's Zosyn™ per the physician's orders with the flow rate. During a review of the facility provided P&P titled, Admixing Medications, last revised 1/2025, the P&P indicated, A. The appropriate diluent is to be used when admixing medications. B. Admixed IV solutions must have a completed medication added label attached. IV. Procedure: A. Verify physician order. L. Label IV solution container with medication added label, to include the following: . 5. Route (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and rate . 6. Directions for administration. During a review of the facility provided P&P titled, Medication Administration and Monitoring (Sub Acute), effective date 3/2025, the P&P indicated, The Registered Nurses and Licensed Vocational Nurses are responsible for the accurate administration and documentation of medications. The purpose of this policy is to safely and accurately administer medications to residents by those authorized to do so as defined by their scope of practice. D. All medication orders are reviewed by a pharmacist prior to administration to a resident unless a licensed independent practitioner controls the ordering, preparation, and administration of the medication; or in urgent situations, when the resulting delay would harm the resident, including situations in which the resident experiences a sudden change in clinical status. E. Healthcare providers administering medications are responsible for knowing and understanding the dosage, indications, side effects and precautions/warnings of the medications being administered. Medications are administered exactly as ordered. All medications are appropriately labeled. b. During a review of Resident 5's H&P, dated 9/8/2025, the H&P indicated the facility admitted the resident on 9/7/2025 with diagnoses including acute (a sudden, severe worsening) on chronic respiratory failure after trauma, cervical spine fracture (commonly known as broken neck), diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing), and motor vehicle accident. During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident has unclear speech, adequate hearing, makes self understood, and had the ability to understand others. The MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated Resident 5 received insulin since admission. During a review of Resident 5's physician order, dated 9/7/2025, the physician order indicated insulin regular (Humulin R) injection vial zero (0) to 12 units, subcutaneous (delivers medication into the fatty tissue layer between the skin and muscle), to administer per correctional scale with associated diagnosis diabetes. During a concurrent observation and interview on 3/24/2026 at 3:58 p.m., with Registered Nurse (RN) 4, observed in Med Cart 1 stored Resident 5's one (1) Humulin R vial with filled date 2/3/2026, opened date 2/14/2026, and expiration date 3/17/2026. RN 4 stated this should have been discarded on 3/17/2026 and should not been in use. During an interview on 3/27/2026 at 11:04 a.m., with the Clinical Educator (CE), the CE stated they follow the pharmacy guidelines and their facility's pharmacy policy for insulin. The CE stated the storage lifetime is indicative of the medication's effectiveness. The CE stated that when insulin is past its storage lifetime it should be discarded because when administered it can affect the effectiveness in blood sugar control which can vary depending on each resident's body's reaction can be hypoglycemia or hyperglycemia. During a review of the Manufacturer's Prescribing Information (MPI), revised 6/2023, the MPI indicated that when stored at room temperature, Humulin R can only be used for a total of 31 days including both not in-use (opened) and in-use (opened) storage time. During a concurrent interview and record review on 3/27/2026 at 11:12 a.m., with the Director of Post (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Acute Care Services (DPACS), reviewed the facility's P&P titled, Insulin Storage, last reviewed 1/2025, the P&P indicated that Humulin R stored opened for 31 days. The DPACS stated insulin regular Humulin R should only be stored for 31 days per their pharmacy policy. The DPACS stated it should be removed from the medication cart and discarded after 31 days.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure medical records were maintained in accordance with professional standards that were complete and accurately documented when the facility failed to ensure Resident 20's Certified Nursing Assistant (CNA) documentation every two hours when Resident 20 was repositioned. This deficient practice had the potential for incomplete and inaccurate medical documentation. Findings: During a review of Resident 20's History and Physical (H&P), dated 1/28/2026, the H&P indicated that the facility admitted the resident on 1/27/2026 with diagnoses including chronic hypoxemic respiratory failure (a long-term condition where the lungs cannot adequately transfer oxygen into the blood, resulting in consistently low blood oxygen levels), ventilator (a medical device to help support or replace breathing) dependent, and chronic neurological encephalopathy (a long-lasting, often progressive brain disease where damaged brain cells cause permanent impairment in thinking, memory, behavior, and movement). During a review of Resident 20's Minimum Data Set (MDS- a resident assessment tool), dated 2/3/2026, the MDS indicated the resident was comatose (of or in a state of deep unconsciousness for a prolonged or indefinite period), dependent on activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and mobility, and at risk of developing pressure ulcers/injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 20's Care Plan (CP) titled, Wound, added 1/27/2026, the CP indicated the resident with goals of optimal wound healing with interventions including reposition every 2 hours and as needed. During a concurrent interview and record review on 3/27/2026 at 6:39 a.m., with CNA 3, reviewed Resident 20's Flowsheet Data, dated 3/19/2026 to 3/20/2026, CNA 3 stated he starts his shift at 7 p.m. and documented the following: - 3/19/2026 at 8:05 p.m. resident lying supine - 3/19/2026 at 9:30 p.m. resident lying supine, CNA 3 stated he did not reposition resident because he did not look comfortable, so he left the resident lying supine. - 3/19/2026 at 2:30 a.m. resident lying supine, CNA 3 stated he provided bath to the resident. - 3/19/2026 at 3:00 a.m. resident lying right-side lying. - 3/19/2026 at 5:20 a.m. resident lying supine. CNA 3 stated he missed 3/20/2026 at 12 a.m. documentation. CNA 3 stated Resident 20 was left side lying but he missed it. CNA 3 stated he was supposed to chart every 2 hours to make sure that they are turning and repositioning the resident and what care he provided to the resident. CNA 3 stated if it was not documented then it did not happen. CNA 3 stated Resident 20 needs to be repositioned every 2 hours because resident is totally dependent on bed mobility and is unable to turn himself. During an interview on 3/27/2026 at 10:04 a.m., with the Clinical Educator (CE), the CE stated CNAs document what care they provided such as incontinence care throughout their shift, repositioning every 2 hours, vital signs every shift in the quickchart (electronic health record). The CE stated turning/repositioning the resident every 2 hours is documented around 8-10-12-2-4-6 within that timeframe that their policy is being followed. The CE stated that when repositioning every 2 hours is not documented pressure injuries can occur and possible respiratory complications from stagnation and may missed catching it because that is supposed to be rounded on (regular checks on the resident). During a review of the facility's policy and procedure (P&P) titled, Documentation, Clinical (Sub Acute), last approved 3/2025, the P&P indicated that the purpose of this P&P is To ensure all information pertinent to each resident's individual care are accurately and effectively communicated. The P&P indicated procedures/general instructions included 1. All clinical documentation reflects a systematic, interdisciplinary approach to resident care. Care is based on outcomes/goals listed in the care plan. 3. Clinical documentation includes, but is not limited to the following:. B. Care and treatment of resident.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure Licensed Vocational Nurse (LVN) 1 disinfected the computer mouse (a small, handheld device used to control a computer) after if fell on the floor and prior to use during the Medication Administration Task for two of four sampled residents (Residents 19 and 24). This deficient practice had the potential to spread communicable diseases and infections among staff and residents. Findings: a. During a review of the facility's census (lists typically contain resident names, locations (unit/room), and the dates of admission), the facility's census indicated the facility originally admitted Resident 24 on 12/16/2022 and readmitted on [DATE]. During a review of Resident 24's History and Physical (H&P), dated 12/10/2025, the H&P indicated the resident had diagnoses including acute respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy (opening surgically created through the front of the neck and into the trachea [windpipe]), and percutaneous endoscopic gastrostomy (PEG, GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement. During a review of Resident 24's Minimum Data Set (MDS - a resident assessment tool), dated 1/29/2026, the MDS indicated the resident was rarely/never able to make herself understood and rarely/never able to understand others. The MDS indicated the resident was dependent on staff for oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 24's care plan (CP) titled, Adult.Plan of Care . start date 3/4/2026, the CP indicated a goal that the resident would have the absence of illness or injury with interventions including to prevent infection by identifying sources of infection early to prevent infection. b. During a review of the facility's census, the facility's census indicated the facility originally admitted Resident 19 on 3/9/2023 and readmitted on [DATE]. During a review of Resident 19's H&P, dated 12/10/2025, the H&P indicated the resident had diagnoses including communicating hydrocephalus (a type of brain injury), tracheostomy, pneumonia (a respiratory infection) and PEG placement. During a review of Resident 19's MDS dated [DATE], the MDS indicated the resident was in a persistent vegetative state (a person is awake but shows no signs of awareness) / no discernible consciousness (awareness of internal and external existence). During a review of Resident 19's CP titled, Infection, start date 9/23/2025, the CP indicated a goal that the resident would have the absence of infection signs and symptoms including interventions to prevent infection to promote early source control to prevent spread of infection. During a medication administration observation on 3/25/2026 at 8:28 a.m. with LVN 1 at Station One medication cart, observed LVN 1 prepare Resident 24's medications in the hallway outside Resident 24's room. Observed during the preparation of the medications LVN 1 referred to the resident's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) in the computer located on the workstation on wheels (WOW). Observed LVN 1 used a computer mouse attached by a long wire to scroll between physician's orders while simultaneously removing each medication from the bubble packs (package that contains multiple sealed compartments with medication). Observed the computer mouse dropped on the floor in the hallway two times during the medication preparation. Observed LVN 1 used hand sanitizer to clean his hands after placing the mouse from the floor onto the WOW but did not disinfect the computer mouse. Observed LVN1 returned to using the mouse and removing the medications from the bubble packs and placing the medication in individual clear plastic cups, crushed the medications, then entered Resident 24's room and administered the medication from the cups by GT. LVN 1 then exited Resident 24's room and began to prepare medications for Resident 19. LVN 1 did not disinfect the computer mouse. During a medication administration observation on 3/25/2026 at 9:15 a.m. with (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 1 at Station One medication cart, observed LVN 1 prepare Resident 19's medications in the hallway outside Resident 19's room. Observed during the preparation of the medications LVN 1 referred to the resident's MAR in the computer located on the WOW. Observed LVN 1 used the computer mouse to scroll between physician's orders while simultaneously removing each medication from the bubble packs. Observed the computer mouse dropped on the floor in the hallway one time during the medication preparation. Observed LVN 1 used hand sanitizer to clean his hands after placing the mouse from the floor onto the WOW but did not disinfect the computer mouse. Observed LVN1 returned to using the mouse and removing the medications from the bubble packs and placing the medication in individual clear plastic cups, crushed the medications, then entered Resident 19's room and administered the medication from the cups by GT. LVN 1 then exited Resident 19's room. During a follow-up interview on 3/25/2026 at 9:39 a.m. with LVN 1, immediately following Resident 19's medication administration observation, LVN 1 stated the computer mouse dropped on the floor three times during Resident 24 and 19's medication administration. LVN 1 stated he performed hand hygiene but did not disinfect the computer mouse and then continued using the mouse while pulling the medications from the bubble packs. LVN 1 stated he (LVN 1) should have disinfected the computer mouse, but he did not. LVN 1 stated when the computer mouse was not disinfected there was the potential for cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) and transferring germs from the floor to the WOW and the residents' medications. During an interview on 3/25/2026 at 8 a.m. with Registered Nurse (RN) 1, RN 1 reviewed the facility's policy and procedures (P&P) regarding medication administration and infection control. RN 1 stated LVN 1 should have disinfected the computer mouse during the medication preparation because there was potential for cross contamination. RN 1 stated the facility P&Ps were not followed. During a review of the facility provided P&P titled, Medication Administration and Monitoring (Sub Acute), effective date 3/2025, the P&P indicated, The purpose of this policy is to safely . administer medications to residents by those authorized to do so as defined by their scope of practice. G. eMAR represents the official and real-time document for active medication orders and should be reviewed to identify medications. H. Perform hand hygiene thoroughly before preparing or measuring medications. During a review of the facility provided P&P titled, Cleaning and Disinfection of Moveable Medical Equipment, last revised 12/2024, the P&P indicated, all moveable medical equipment should be routinely cleaned and disinfected. The purpose of this clinical standard is to establish responsibility and frequency for cleaning and disinfecting moveable medical equipment and to prevent transmission of organisms.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to screen for, offer, and administer the pneumonia vaccine (medication used to prevent serious lung infections caused by streptococcus pneumoniae [types of bacteria]) for one of five sampled residents (Resident 5) reviewed during the Infection Control task. This deficient practice had the potential to result in serious respiratory infection from pneumonia in Resident 5. Findings: During a review of the facility's census (lists typically contain resident names, locations (unit/room), and the dates of admission), the facility's census indicated the facility admitted Resident 5 on 9/7/2025. During a review of Resident 5's History and Physical (H&P), dated 9/8/2025, the H&P indicated the resident had diagnoses including chronic (long-term) respiratory failure (serious condition that slowly develops when the lungs cannot get enough oxygen into the blood), tracheostomy (opening surgically created through the front of the neck and into the trachea [windpipe]), asthma (a chronic condition that affects the airways in the lungs) and gastrostomy tube (GT - a tube placed directly into the stomach to give direct access for supplemental feeding, hydration, or medicine) placement. During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2025, the MDS indicated the resident was able to make himself understood and able to understand others. The MDS further indicated the resident was dependent on staff for personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 5's care plan (CP) titled, Infection, start date of 10/2/2025, the CP indicated a goal that the resident would have the absence of infection signs and symptoms. During a review of Resident 5's facility provided immunization record titled, California State Registry, dated 3/18/2026, the immunization record indicated Resident 5 had received four doses of the pneumococcal 7-valent conjugate vaccine (PCV7 vaccine - a vaccine used to prevent infections caused by seven common serotypes [strain] of the bacterium streptococcus pneumoniae) at the following date and times: 12/26/2003, 4/2/2004, 6/19/2004, and 12/26/2006. During a concurrent interview and record review on 3/26/2026 at 9:38 a.m. with the Infection Preventionist (IP), the IP reviewed Resident 5's California Immunization Record Report (CAIR2 - a secure, confidential, statewide immunization system for California residents) undated, and the Centers for Disease Control and Prevention (CDC) document titled, Pneumococcal Vaccine Timing for Adults, dated 3/2025 . The IP stated there are various pneumonia vaccines used to prevent or minimize respiratory complications from pneumonia. The IP stated at admission and annually she (IP) questions the resident or family member and uses CAIR2 to screen for and offer vaccines. The IP stated there is a CDC tool to determine if a resident qualifies to receive any further doses of the pneumonia vaccines. The IP stated Resident 5 received 4 doses of PCV7 between 2003 to 2006. The IP stated CAIR2 indicated Resident 5's pneumonia vaccination was complete, so she did not screen to see if Resident 5 qualified for any further pneumonia vaccines. The IP then reviewed the CDC tool and stated Resident 5 qualified for and should have received the PCV15 (vaccine that protects against 15 strains of Streptococcus pneumoniae bacteria), PCV20 (vaccine that protects against 20 strains of Streptococcus pneumoniae bacteria), or the PCV21 (vaccine that protects against 21 strains of Streptococcus pneumoniae bacteria) pneumonia vaccine but he did not receive any further doses. The IP stated she should have further screened Resident 5 using the CDC tool but did not. During a concurrent interview and record review on 3/26/2026 at 4 p.m. with Registered Nurse (RN) 1, RN 1 reviewed the facility policy and procedure (P&P) regarding vaccination. RN 1 stated vaccinations are important to prevent residents from getting critically ill from pneumonia. RN 1 stated the facility process is to screen for and offer vaccinations at admission and as needed, get consent, educate on the risk and benefits, and administer vaccinations with a physician's order. RN 1 stated when Resident 5 qualified for and did not receive further doses of the pneumonia vaccine, the facility P&P was not followed. During a review of the facility provided CDC document titled, Pneumococcal Vaccine Timing for Adults, dated (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/2025, the Pneumococcal Vaccine Timing for Adults document indicated age [AGE] to 49 with certain underlying medical conditions or other risk factors** who have not previously received a PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown: one [1] dose PCV15 or 1 dose PCV20 or 1 dose PCV 21. previously received only PCV7: follow recommendations above. Underlying medical conditions or other risk factors include. chronic . lung disease. During a review of the facility provided P&P titled, Vaccines (. Pneumococcal) - (Sub-Acute), last reviewed 3/2025, the P&P indicated, it is the policy . to reduce the potential for transmitting and/or contracting influenza and/or pneumonia among Sub-Acute residents. PURPOSE. To ensure that . pneumococcal vaccines are offered and administered to each resident of the Sub-Acute Unit. E. Center for Disease Control and Prevention Guidelines are followed for administration of . pneumonia vaccine. 3. Pneumococcal disease A. Before offering the pneumococcal immunization, each resident or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization. B. Offer each resident a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized. C. Resident or resident's legal representative has the opportunity to refuse immunization; and D. Indicate in resident's medical record, includes documentation indicating, minimum, of the following: a. Provide resident or resident's legal representative education regarding benefits and potential side effects of pneumococcal immunization; and b. Resident either received a pneumococcal immunization or did not receive pneumococcal immunization due to medical contraindication or refusal and reason for the refusal. c. Exception: as an alternative, based on an assessment and practitioner recommendation, second pneumococcal immunization given after 5 years following first pneumococcal immunization, unless medically contraindicated or resident or resident's legal representative refuses second immunization. 4. Administration of Vaccine A. Obtain vaccines from the provider pharmacy. C. Vaccines administered to residents WITH consent, or legal representative, received education on the benefits and potential side effects, by a Licensed Nurse according to manufacturer's directions.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post the daily staffing posting that contained the total number of staff and actual hours worked per shift information for 7 p.m. to 7 a.m. night shift for four (4) of 4 days reviewed for Sufficient and Competent Staffing Task. This deficient practice had the potential to keep residents and visitors unaware of total number of staff and the actual hours worked by staff in the facility. Findings: During an observation on 3/23/2026 at 7:46 a.m., observed posting titled, STAFFING FOR TODAY on top of the nursing station countertop, dated 3/20/2026, the posting indicated a census of 46 but did not indicate the total number of staff for the night shift and did not indicate the actual worked hours by the Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), and Certified Nursing Assistants (CNAs) per shift. During a concurrent interview and record review on 3/23/2026 at 2:41 p.m. with RN 2, the facility's Staffing for Today posting, dated 3/18/2026, 3/19/2026, and 3/20/2026, were reviewed. RN 2 stated she could not find postings for 3/21/2026 and 3/22/2026. RN 2 stated the posting did not have information for the night shift because they do not have a secretary at night. RN 2 stated they have a secretary in the morning that is responsible for completing the staffing for today for day shift, 7 a.m. to 7 p.m. shift. During an interview on 3/23/2026 at 2:53 p.m. with Administrative Assistant (ADTA) 1, ADTA 1 stated that part of her duties is to fill out the staffing for today for the day shift and for the night shift the charge nurse for the night shift fills it out. ADTA 1 stated in the posting she fills out the census, the date, and the number of staff on duty for day shift. ADTA 1 stated that is all she fills out on the form.^ During a concurrent interview and record review on 3/26/2026 at 7:26 a.m. with RN 3, the facility's Staffing for Today posting, dated 3/18/2026, 3/19/2026, 3/20/2026, and 3/23/2026, were reviewed. RN 3 stated they use this form Staffing for Today to post their staffing information. RN 3 stated they have always used this form in the station since she started. RN 3 stated the secretary usually fills it out and pre-fills it out for the night shift. RN 3 stated they, charge nurses for night shift, have not filled out this form. RN 3 stated the purpose of this form is to show their staffing information and if they are meeting the staffing regulations and if they meet the standards with the number of nurses per shift. RN 3 stated this is to ensure safe and adequate staffing for their residents and families and administration are aware of their staffing. RN 3 stated it would seem that nobody is working or not know how many are working on that shift. RN 3 stated when the staffing posting information is not completed per shift then they are not informing the public about their staffing information. During an interview on 3/27/2026 at 11:48 a.m. with the Director of Post Acute Care Services (DPACS), the DPACS stated the staffing posting information are inputted by the night shift charge nurse. The DPACS stated they do not have a policy for staffing posting information, but they follow the Centers for Medicare and Medicaid Services (CMS - federal agency within the Department of Health and Human Services that manages government health coverage programs regulation for staffing posting).^