

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555132	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave North Hollywood, CA 91606	
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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the call light (an alerting device for nurses or other nursing personnel to assist a resident when in need) was within reach and the appropriate type of call equipment was placed and the pad call light (a specialty alerting device that have ultra-sensitive touch surface for patients with limited mobility for nurses or other nursing personnel to assist a resident when in need) for four of four sampled residents (Residents 20, 34, 63, and 66) reviewed under environment task. This deficient practice had the potential to result in a delay of care and services, possible injury, and inability for Residents 20, 34, 63, and 66 to summon health care workers for assistance or adjust their beds for comfort as needed. Findings: 1. During a review of Resident 20's admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2025, with diagnoses including contracture of muscle (an involuntary tightening or shortening of a muscle that makes it stiff and hard to stretch), generalized anxiety disorder (GAD, a mental health condition characterized by constant, excessive, and uncontrollable worry about everyday life events (like work, health, or finances) that lasts for at least six months), and dementia (a progressive state of decline in mental abilities). During a review of Resident 20's History and Physical (H&P), dated 11/11/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated the resident had severe cognitive impairment (a profound loss of mental abilities—such as memory, reasoning, and focus—that disrupts a person's ability to live independently) and was dependent to needing substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 20's Order Summary Report (OSR), dated 3/27/2026, the OSR indicated an order for Restorative Nursing Assistant (RNA) to apply bilateral elbow splints (a supportive device used to protect, rest, or immobilize the elbow joint while it heals) and bilateral wrist/hand splints 4 hours or as tolerated with skin checks, once daily (QD) 5 times per week. During a review of Resident 20's Fall Risk Evaluation (FRE), dated 3/2/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 20's Care Plan (CP) Report regarding the resident having behavioral patterns of schizophrenia (a mental illness that is characterized by disturbances in thought) manifesting behavior of physical aggression., last revised on 5/6/2026, the CP indicated an intervention that call light will be within reach at all times. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/18/2026, with Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1, inside Resident 20's room, observed Resident 20's call light cord was nowhere to be found. CNA 1 stated she found the call light cord at the back of the curtain not accessible for the resident to use. CNA 1 stated the resident will not be able to use the call light because the resident had bilateral elbow splints and bilateral wrist/hand splints. LVN 2 stated they should have assessed the resident and provided a special pad call light so the resident can call for help without using her hands. CNA 1 and LVN 1 stated the failure of the staff to keep the call light cord within reach and their failure to provide a special call light for the resident had a potential for the resident not being able to call or ask for help when needed. During an interview and record review on 5/20/2026, at 10:53 a.m., with the Minimum Data Set Coordinator (MDSC), reviewed Resident 20's OSR, FRE, CP, and policies and procedures (P&Ps) for call lights. The MDSC stated the resident was a fall risk resident and had an order for bilateral arm splints. The MDSC stated the CP regarding the resident having behavioral patterns of schizophrenia with an intervention to keep the call light within reach was not followed. The MDSC stated it was the responsibility of all staff to keep the call light within the reach of Resident 20 and the licensed staff should have assessed the need for special pad call light for the resident as the resident had bilateral arm splints. The MDSC stated the failure of the staff to keep the call light cord within reach and by failing to assess the need for special pad call light on the resident had predisposed the resident for unmet needs because the resident cannot call for assistance. The MDSC also stated the staff did not follow the P&P of the facility on call lights. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated the staff should have kept the call light within the reach of Resident 20 and the licensed staff should have assessed the resident on the need for special pad call light for the resident to use. The DON stated the resident cannot use the regular call light as the resident had bilateral arm splints. The DON stated the failure of the staff to keep the call light within reach and assessed for appropriate type of call light had predisposed the resident for delayed treatment because the resident will not be able to make her needs known. 2. During a review of Resident 34's AR, the AR indicated the facility admitted the resident on 2/15/2019, and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (a stroke (blocked blood flow in the brain) caused damage in the brain, leading to either weakness or complete loss of movement on the left side of the body); other lack of coordination (trouble with balance or movement); contracture, left hand (the left hand has become tight or stiff, making it hard to straighten or move the hand normally). During a review of Resident 34's H&P, dated 1/31/2026, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 34's MDS, dated [DATE], the MDS indicated the resident had the ability to usually make self understood, understand others, and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated the resident was dependent to moderate assistance on mobility and ADLs. During a concurrent observation and interview on 5/18/2026, at 9:55 a.m., with CNA 5 in Resident 34's room, the resident was observed lying in bed and the pad call light on the floor on the right side of the bed. CNA 5 stated if the resident falls, the resident would get hit on the (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make her needs known. The MDS further indicated Resident 66 had impairment of both upper and required substantial/maximal assistance to total assistance from staff with all ADLs. During a review of Resident 66's fall risk evaluations, dated 2/20/2026 and 5/6/2026, the fall risk evaluations indicated that Resident 66 was at a high risk for falls. During an observation on 5/18/2026 at 9:31 a.m. inside Resident 66's room, observed Resident 66 was lying in bed and continuously talking, unable to understand and answer appropriately and that the call light was not within Resident 66's reach and not on top of the bed. Observed Resident 66 with a yellow wrist band and bilateral floor mats. During a concurrent observation and interview on 5/18/2026 at 10:40 a.m. inside Resident 66's room with CNA 1, CNA 1 stated Resident 66 had weakness on both upper extremities and that the call light cord was behind the headboard down to the floor. CNA 1 stated that Resident 66 was unable to reach the call light. CNA 1 stated that the staff should make sure that the call light was within the residents' reach prior to leaving the room, especially residents who were unable to move both arms and legs, so they can call for assistance. CNA 1 stated that Resident 66's call light should have been placed within his reach so Resident 66 can call for assistance. CNA 1 stated if the call light was not within Resident 66's reach, the resident would not be able to call for assistance and placed him at risk for a delay in providing the care and services Resident 66 needs. During a concurrent interview and record review on 5/20/2026 at 10:54 a.m. Resident 66's fall risk assessments, and MDS assessment were reviewed with the MDSC. The MDSC stated that the fall risk assessments indicated that Resident 66 was at a risk for falls and that the MDS assessment indicated that Resident 66 had impairment on both upper extremities. The MDSC stated that staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. The MDSC stated Resident 66's call light should have been placed within the resident's reach as Resident 66 had an impairment on both upper extremities. The MDSC stated that Resident 66 would not be able to call for assistance and the staff would not be able to provide the proper care timely to the resident when needed. During an interview on 5/21/2026 at 2 p.m. with the DON, the DON stated that the staff are supposed to ensure that the call lights are placed within the residents' reach after providing care and prior to leaving the room. The DON stated the call lights should be accessible to the residents at all times. The DON stated that Resident 66's call light should have been placed within the resident's reach as Resident 66 had impairment on both upper extremities and blind and would not be able to reach the call light if the cord was behind the headboard down to the floor. The DON stated that Resident 66 would not be able to call for assistance and placed Resident 66 at risk for delay in receiving the care he needed. During a review of the facility's recent P&P titled, Answering the Call Light, last reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to ensure timely responses to the resident's requests and needs. General Guidelines (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.ˆ		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and provide a written information to all adult residents concerning the right to accept and refuse medical surgical treatment and, at the resident's option to formulate an advance directive (a legal document indicating resident preference on end-of-life treatment decisions) to three of three sampled residents (Residents 8, 42, and 5) by the Social Services Director (SSD) by failing to: 1. Offer advance directive formulation information to Resident 8. 2. Complete the advanced directive acknowledgement form for Residents 42 and 5. The deficient practices violated the resident's rights and/or representative's right to ensure the resident's end-of-life treatment decisions were readily available for staff to honor and implement. Findings: 1. During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted the resident on 9/4/2025, with diagnoses including end stage renal disease (End Stage Renal Disease-irreversible kidney failure), dependence on renal dialysis (a person relies on a medical treatment or machine to clean their blood and remove excess fluid because their kidneys are no longer working well enough to do it themselves), and hypertensive heart disease with heart failure (heart damage caused by years of unmanaged high blood pressure). During a review of Resident 8's History and Physical (H&P), dated 9/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (an in-between stage of mental decline where memory and thinking troubles are noticeable enough to family and friends, yet not severe enough to stop the person from living independently). During a concurrent interview and record review on 5/19/2026, at 9:30 a.m., with Registered Nurse (RN) 1, Resident 8's electronic healthcare records and physical chart were reviewed. RN 1 stated she (RN 1) did not find the advanced healthcare directive acknowledgment form (AHDAF) in both platforms and she (RN 1) went to check with the Medical Record Director (MRD) if there was one in the old files and found none. RN 1 stated it was important to have the AHDAF to ensure the advance healthcare directive information formulation was provided to the resident or representative. During a concurrent interview and record review on 5/20/2026, at 10:23 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 8's electronic healthcare records, physical chart, and policies and procedure (P&P) were reviewed. The MDSC stated it was the primary responsibility of the Social Services Director (SSD) to ensure the AHDAF was provided to the resident. The MDSC stated it was important to offer the AHDAF to ensure resident's wishes were honored during end-of-life care to know if the resident wanted to have heroic efforts to be done or let nature to take its course on the resident during end of life. The MDSC stated their P&P for Advanced Directives were not followed. The MDSC stated their failure to offer the information for advanced healthcare directive formulation had the potential of not honoring the resident's wishes during end of life. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated the facility staff should have offered the AHDAF to Resident 8 to ensure the resident's wishes for end-of-life care was followed. The DON stated an example of the information needed from the advanced healthcare directive that the staff needed readily available was to code or not to code the resident when the resident goes into cardiopulmonary arrest (when a person's heart suddenly stops pumping blood and they stop breathing normally). 2. During a review of Resident 42's AR, the AR indicated the facility admitted the resident on 1/27/2026, and readmitted the resident on 5/2/2026, with diagnoses including sepsis (a life-threatening blood infection), acute respiratory failure (a life-threatening medical emergency where your lungs suddenly cannot get enough oxygen into your blood or fail to remove enough carbon dioxide) with hypoxia (a dangerous condition where your body's tissues and organs do not get enough oxygen to function properly), and (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for three of four sampled residents (Residents 20, 57, and 2) reviewed for physical restraints by failing to ensure: 1. Resident 20's use of restraint pillow tucked under the sheets had a physician's order, informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), restraint assessment, and a care plan. The deficient practices had the potential to result in the restriction of the resident's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from the resident limbs getting entrapped from bed spaces leading to fractures (a broken bone) even death. 2. Residents 57 and 2 did not have pillows tucked under the fitted sheet. These deficient practices had the potential to result in the restriction of the residents' freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment (a state in which a person is trapped by the bed rail in a position that they cannot move from), and result in injury or death. Findings: a. During a review of Resident 20's admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2025, with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought), dementia (a progressive state of decline in mental abilities), and epilepsy (a chronic brain disorder characterized by recurring, unprovoked seizures). During a review of Resident 20's History and Physical (H&P), dated 11/11/2025, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 20's Minimum Data Set (MDS, a resident assessment tool), dated 3/27/2026, the MDS indicated the resident had severe cognitive impairment (a person has lost their mental capacity to the point where they cannot live independently or care for themselves) and was dependent to needing substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 20's Order Summary Report (OSR), dated 5/20/2026, the OSR did not indicate an order for restraint pillows tucked under the sheets. During a review of Resident 20's Fall Risk Evaluation (FRE), dated 3/2/2026, the FRE indicated the resident was at risk for falls. During a concurrent observation and interview on 5/18/2026, at 9:50 a.m., with Certified Nursing Assistant (CNA) 1 and Licensed Vocational Nurse (LVN) 1, inside Resident 20's room, observed Resident 20 had a pillow tucked under the sheets on the right back side of the resident. CNA 1 and LVN 1 both stated the pillows should not be tucked under the sheets as the resident will not be able to remove them easily, limiting the resident's repositioning in bed. CNA 1 and LVN 1 stated tucking a pillow under the sheet was a restraint. During a concurrent interview and record review on 5/20/2026, at 10:45 a.m., with the the Minimum (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave North Hollywood, CA 91606	
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Data Set Coordinator (MDSC), Resident 20's OSR, FRE, and facility's policy and procedures (P&P) were reviewed. The MDSC stated the pillows tucked under the sheets of Resident 20 was a restraint. The MDSC stated the resident will have a hard time removing the pillows as they were tucked under the sheets limiting the residents repositioning in bed. The MDSC stated before applying a restraint they should have a physician's order, informed consent from the resident or representative, a restraint assessment, and a care plan on its use. The MDSC stated the OSR did not have all the four components needed to apply a restraint. The MDSC also stated the P&P for restraint was not followed. The MDSC stated the failure of the licensed nurses to obtain a physician's order, informed consent, restraint assessment and a care plan predisposed the resident to accidents such as falling on a higher ground due to rolling over the pillow and potential for development of pressure injury due to positioning limitation brought about by the pillow tucked under the sheets. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated Resident 20's pillows tucked under the sheets was a restraint and should have a physician's order, informed consent, restraint assessment, and a care plan on its use. The DON stated the failure of the staff to obtain all the required elements predisposed the resident to restriction of resident's mobility, skin breakdown, and accidents such as falling on a higher ground that can cause fracture. During a review of the facility's recent P&P titled, Use of Restraints, last reviewed on 4/23/2026, the P&P indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried successfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. Policy Interpretation and Implementation 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, Geri-chairs, cushions and trays that the resident cannot remove. 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: a. The specific reason for the restraint (as it relates to the resident's medical symptom); b. How the restraint will be used to benefit the resident's medical symptom; and c. The type of restraint, and period of time for the use of the restraint. 18. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During a review of Resident 57's AR, the AR indicated the facility originally admitted Resident 57 on 9/10/2024, and readmitted in the facility on 1/30/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), functional quadriplegia (the complete inability to move due to severe disability or frailty) a medical condition of reduced function and health in older individuals caused by another medical condition without physical injury or damage to the spinal cord), schizophrenia (a mental illness that is characterized by disturbances in thought), adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), and lack of coordination. During a review of Resident 57's H&P, dated 10/6/2025, the H&P did not indicate Resident 57's capacity to understand and make decisions. During a review of Resident 57's MDS, dated [DATE], the MDS indicated Resident 57 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) but was able to understand and make her needs known. The MDS further indicated Resident 57 required supervision/touching assistance with rolling to left and right; total assistance with toileting bathing, sit to stand, and transfers; substantial/maximal assistance with lower body dressing and lying to sitting; partial/moderate assistance with all other activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 57's fall risk evaluations dated 10/6/2025, 10/24/2026, and 3/16/2026, the fall risk evaluations indicated that Resident 57 was at a high risk for falls. During an observation on 5/18/2026 at 10:26 a.m. inside Resident 57's room, observed Resident 57 lying in bed asleep. Observed two (2) pillows on each side were tucked under Resident 57's fitted sheet on both sides of the bed. During a concurrent observation and interview on 5/18/2026 at 10:29 a.m., inside Resident 57's room with CNA 2, CNA 2 stated Resident 57 had two pillows each side tucked under the fitted sheet on both sides of the bed. CNA 2 stated she (CNA 2) is not the CNA assigned to the resident and the staff are supposed to place the pillows on top of the fitted sheet. CNA 2 stated that the pillows are placed to prevent the residents from falling. CNA 2 stated that Resident 57 was unable to remove the pillows by herself if tucked under the fitted sheet and prevented her from getting out of the bed by herself. During a concurrent observation and interview on 5/18/2026 at 10:34 a.m., inside Resident 57's room with CNA 1, CNA 1 stated that every day that she (CNA 1) is assigned to the resident, she (CNA 1) puts two pillows under the fitted sheet on both sides of the bed because Resident 57 is moving a lot in bed and is at risk for falls. CNA 1 stated that she (CNA 1) put the pillows under the fitted sheet to prevent Resident 57 from falling. During a concurrent observation and interview on 5/18/2026 at 10:46 a.m. inside Resident 57's room with LVN 1, LVN 1 stated two pillows on each side of Resident 57 were tucked under the fitted sheet. LVN 1 stated that Resident 57 cannot remove the pillows by herself if tucked under the fitted sheet. LVN 1 stated that the placement of pillows under the fitted sheet restricts Resident 57's freedom of movement and can be considered a restraint. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/20/2026 at 10:46 a.m., with the MDSC, Resident 57's physician's orders, care plan, informed consent, restraint assessment, and fall risk evaluations for 10/6/2025, 10/24/2026, and 3/16/2026 were reviewed. The MDSC stated that Resident 57's fall risk evaluations indicated that Resident 57 was at a high risk for falls, and there was no physician's order to place the pillows under the fitted sheet. The MDSC stated that Resident 57 was unable to remove the pillows if tucked under the fitted sheet due to the resident's frailty. The MDSC stated that the pillows under the fitted sheet can be considered a restraint as it was restricting the resident to move freely. The MDSC stated that the pillows can be used only for repositioning but should be placed on top of the fitted sheet. The MDSC stated that Resident 57's pillows should have been placed on top of the fitted sheet as it restricts Resident 57 to move freely which can lead to further decline in functioning. During an interview on 5/21/2026 at 2:26 p.m. with the DON, the DON stated that when applying a restraint on a resident, there should be a restraint assessment, physician's order, informed consent, and care plan. The DON stated that pillows are primarily used as positioning devices and are supposed to be placed by staff on top of the fitted sheet where the residents can remove it on their own and be able to move freely. The DON stated that placing the pillows under the fitted sheet restricts a resident's movement and the residents are unable to remove the device, hence, considered a restraint. The DON stated that the staff should not have placed the pillows under Resident 57's fitted sheet as the resident was unable to remove the pillows freely and restricted the resident to move freely which can lead to a skin breakdown and further decline in physical functioning. During a review of the facility's P&P titled, "Use of Restraints, last reviewed on 4/23/2026, the P&P indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried successfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. The P&P further indicated: Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, cushions and trays that the resident cannot remove. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following: The specific reason for the restraint (as it relates to the resident's medical symptom); How the restraint will be used to benefit the resident's medical symptom; and The type of restraint, and period of time for the use of the restraint. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use. c. During a review of Resident 2's AR, the AR indicated the facility originally admitted Resident 2 on 6/24/2021 and readmitted on [DATE], with diagnoses including other toxic encephalopathy (the brain is not working properly because it has been affected by harmful substances); hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (A stroke (blocked blood flow in the brain) caused damage in the brain, leading to either weakness or complete loss of movement on the left side of the body); other lack of coordination (trouble with balance or movement). During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident had the ability to usually make self-understood and usually understand others and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated the resident was dependent to maximal assistance on mobility and ADLs. During an observation on 5/18/2026 at 10:46 a.m. inside Resident 2's room, observed Resident 2 lying in bed asleep. Observed pillows tucked under the fitted sheet on left and right side of Resident 2. During a concurrent observation and interview on 5/18/2026 at 10:55 a.m., with CNA 6 inside of Resident 2's room observed pillows tucked under fitted sheet on both sides of resident. CNA 6 stated that there should not be any pillows under the fitted sheet because it restricts movement and it is considered a restraint. During an interview on 5/20/2026 at 10:46 a.m., with the MDSC, the MDSC stated that there was no physician's order to place pillows under Resident 2's fitted sheet. The MDSC stated that Resident 2 would not be able to remove the pillows if tucked under the fitted sheet. The MDSC stated that if the patient cannot remove the pillows from under the fitted sheet and resident cannot reposition then it becomes a restraint. The MDSC stated that the pillows can only be used for repositioning but should be placed on top of the fitted sheet. The MDSC stated that the resident has potential for skin breakdown and physical decline if resident is unable to move. The MDSC stated the policy and procedure Use of Restraints, was not followed. During an interview on 5/21/2026 at 2:26 p.m. with the DON, the DON stated that if restraints are used on a resident, there should be a physician's order, restraint assessment, informed consent, and care plan. The DON stated that when pillows are used for positioning, they are supposed to be placed on top of the fitted sheet where the residents can remove it on their own and be able to move freely. The DON stated that placing the pillows under the fitted sheet restricts mobility and if the residents are unable to remove the pillows, then it is considered a restraint. The DON stated that the staff should not have placed the pillows under Resident 2's fitted sheet as the resident was unable to remove the pillows and restricted the resident from moving freely which can lead to a skin breakdown and further decline in physical functioning. During a review of the facility's recent P&P titled, Use of Restraints, last reviewed on 4/23/2026, the P&P indicated restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried successfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	falls.^^ Policy Interpretation and Implementation^^ 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.^^ 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, Geri-chairs, cushions and trays that the resident cannot remove.^^ 6. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints.^^ 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). The order shall include the following:^^ a. The specific reason for the restraint (as it relates to the resident's medical symptom);^^ b. How the restraint will be used to benefit the resident's medical symptom; and^^ c. The type of restraint, and period of time for the use of the restraint.^^ 18. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use.^^		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Ensure the resident's drug regimen was free from unnecessary drugs for one of five sampled residents (Resident 46) reviewed for unnecessary medications by failing to ensure the facility obtained an informed consent (IC, a voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) on the use of Alprazolam Oral Tablet (a fast-acting prescription tranquilizer used to quickly calm the nervous system) 0.5 milligrams (mg, a unit of weight) tablet by mouth every six hours as needed for anxiety monitor for behavior (m/b) constant complaints of pain for 30 Days. The deficient practice had the potential to result in the use of unnecessary psychotropic drugs (any substance that affects how the brain works, resulting in changes to a person's mood, thoughts, feelings, or behavior) for Resident 46, and can lead to side effect/adverse effect (refers to the negative or harmful results that follow from a particular action or event) such as a decline in quality of life and functional capacity. 2. Ensure the resident's drug regimen was free from unnecessary drugs for one (1) of thirty (30) sampled residents (Resident 66) reviewed during a random record review by: - Failing to ensure the facility obtained an informed consent on the use of lorazepam (a fast-acting prescription medication used to calm the nervous system). - Failing to ensure there was a stop date for the use of lorazepam as needed. - Failing to ensure there was a care plan (CP) developed and implemented for the use of lorazepam. These deficient practices had the potential to result in the use of unnecessary psychotropic drugs (any substance that affects how the brain works, resulting in changes to a person's mood, thoughts, feelings, or behavior) for Resident 66, and can lead to side effect/adverse effect (refers to the negative or harmful results that follow from a particular action or event) such as a decline in quality of life and functional capacity. Findings: a. During a review of Resident 46's admission Record (AR- front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including mood disorder (is a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), generalized anxiety disorder (GAD, a mental health condition characterized by constant, excessive, and uncontrollable worry about everyday life events (like work, health, or finances) that lasts for at least six months), and alcohol dependence (a chronic medical condition characterized by a compulsive need to drink). During a review of Resident 46's History and Physical (H&P), dated 4/11/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of mental decline where memory and thinking problems are noticeable enough to interfere with daily life and independence). The MDS indicated the resident was on a high-risk drug class antipsychotic (prescription medications used primarily to manage conditions that involve psychosis) and antianxiety medications (prescription medications that help calm the brain, balance mood-regulating chemicals, and relieve physical symptoms like a racing heart or tense muscles). During a review of Resident 46's Order Summary Report (OSR), dated 4/30/2026, the OSR indicated an order for Alprazolam Oral Tablet 0.5 mg (Alprazolam). Give one tablet by mouth every six hours as (continued on next page)		

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed for anxiety m/b constant complaints of pain for 30 Days. During a concurrent interview and record review on 5/20/2026, at 3:41 p.m., with the Minimum Data Set Coordinator (MDSC), Resident 46's OSR and IC were reviewed. The MDSC stated there was no IC on the use of Alprazolam Oral Tablet 0.5 mg (Alprazolam) one tablet by mouth every six hours as needed for anxiety m/b constant complaints of pain for 30 Days and psychotropic medications used for as needed (PRN) was only good for 14 days. The MDSC stated that informed consent for psychotropic medications was important to ensure the resident or representative understood the risks and benefits of taking the medication and to give them the opportunity to agree or disagree with the proposed treatment. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated the licensed staff should have obtained an IC from Resident 46 or responsible party for the use of Alprazolam. The DON stated it was important to obtain an IC on the use of psychotropic medication Alprazolam to ensure the risks and benefits were explained to the resident and the use of PRN psychotropic is only limited for 14 days to evaluate its use. The DON also stated using psychotropic medication was a chemical restraint (the use of a medication to restrict a person's movement, sedate them, or control their behavior) that is why the physician had to be aware of its safe use. During a review of the facility's recent policy and procedure (P&P) titled, Psychoactive Medication Informed Consent, last reviewed on 4/23/2026, the P&P indicated it is the policy of this facility to ensure that an informed consent is obtained for each resident's psychoactive medication is authorized in writing by a physician for specified time period and when necessary to protect the resident from self-injury or injury to others. During a review of the facility's recent P&P titled, Psychotropic Medication Use, last reviewed on 4/23/2026, the P&P indicated residents will not receive medications that are not clinically indicated to treat a specific condition. Resident Evaluations 4. Residents (and/or representatives) have the right to decline treatment with psychotropic medications.[^] a. The staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives. 12. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. a. PRN orders for psychotropic medications are limited to 14 days. During a review of the facility provided Highlights of Prescribing Information (HPI) on the use of Alprazolam tablets, for oral use, CIV, with initial U.S. approval in 1981, the HPI indicated a WARNING: Risks from concomitant use with opioids; abuse, misuse, and addiction; and dependence and withdrawal reactions. b. During a review of Resident 66's AR, the AR indicated the facility admitted the resident on (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/20/2026, with diagnoses including visual loss both eyes, lack of coordination, and protein-calorie malnutrition (a condition when the body does not get enough nutrition and the body begins to break down its own muscles, fat, and tissues leading to weight loss). During a review of Resident 66's H&P dated 2/20/2026, the H&P did not indicate Resident 66's capacity to understand and make decisions but indicated that the resident had cognitive impairment. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make her needs known. The MDS further indicated Resident 66 had impairment of both upper and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 66's Order Summary Report dated 5/20/2026, the Order Summary Report indicated the following physician's order dated 5/6/2026: Lorazepam oral tablet one milligram (mg &ndash; a unit of measurement give one tablet by mouth every six (6) hours as needed (PRN) for anxiety (a mental health condition where excessive fear and worry interfere with daily life, causing significant distress) manifested by excessive worrying and screaming, During a review of Resident 66's electronic health record (EHR) and physical or paper medical records, unable to find documented evidence that Resident 66 had an informed IC and CP for the use of lorazepam. During a concurrent interview and record review on 5/21/2026 at 8:54 a.m. with the MDSC, Resident 66's electronic health record (EHR) and physical or paper medical records for physician order, IC, and CPs were reviewed. The MDSC stated Resident 66's physician's order did not indicate a stop date for the use of lorazepam, there was no IC, and a CP was not developed and implemented for the use of lorazepam PRN. The MDSC stated that all PRN orders for psychotropics (any drug that affects behavior, mood, thoughts, or perception) upon admission, should indicate a stop date of 14 days and if the resident still needs the medication, then the physician should evaluate the resident and can order for 30 days to ensure that there is a continued need for the use of the medication. The MDSC stated Resident 66's lorazepam PRN should have an end date. The MDSC stated that if a resident gets readmitted with a new medical record and there was a physician's order for psychotropics, the LNs who received the order should have clarified with the physician the end date for the PRN psychotropic. The MDSC stated that Resident 66's IC should have been obtained from the resident and/or responsible party (RP) to ensure that the resident and/or RP is aware of the risks and benefits for the use of the psychotropics gives them as chance to decline or accept the treatment. The MDSC stated if the IC was not obtained prior to start of lorazepam, it is considered a chemical restraint as lorazepam is a mood-altering medication. The MDSC stated that Resident 66's CP should have been developed and implemented for the use lorazepam when the LNs obtained the order to ensure that the staff is aware of the current plan of care and approaches or interventions to be able to provide the care Resident 66 needed. During an interview on 5/21/2026 at 2:10 p.m. with the DON, the DON stated the LN who received the order for Resident 66's PRN lorazepam did not clarify with the physician the end date, a new IC should be obtained from the resident and/or RP for the use of PRN lorazepam, and the LN who received the (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order for PRN lorazepam did not develop and implement a CP for the lorazepam PRN. The DON stated that Resident 66's PRN lorazepam should have a stop date for the doctor to be able to evaluate the continued need for the medication and to prevent unnecessary use and is considered a chemical restraint as it alters Resident 66's mood. The DON stated Resident 66's PRN lorazepam should have an IC prior to start to give the resident and/or RP the chance to decline or accept the plan of care, and the CP should have been developed and implement so the members of the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) would be aware of the plan of care to provide the care Resident 66 needed. The DON stated that without the stop for the lorazepam PRN, IC prior to start of the lorazepam, and no CP placed Resident 66 at risk for unnecessary medications, and not providing properly the care Resident 66 needed. During a review of the facility's recent policy and procedure (P&P) titled, Goals and Objectives, Care Plans, last reviewed on 4/23/2026, the P&P indicated care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence. During a review of the facility's recent P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/23/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P further indicated: - The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. - The comprehensive, person-centered care plan is developed within seven (7) days of completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. During a review of the facility's P&P titled, Psychotropic Medication Use, last reviewed on 4/23/2026, the P&P indicated that residents will not receive medications that are not clinically indicated to treat a specific condition. The P&P further indicated: - Residents, families, and/or the representatives are involved in the medication management process. Psychotropic medication management includes: a. Indications for use b. Dose (including duplicate therapy) c. Duration d. Adequate monitoring for efficacy and adverse consequences; and e. Preventing identifying and responding to adverse consequences. - Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a. PRN orders for psychotropic medications are limited to 14 days. (1) For psychotropic medications that are not antipsychotics: if the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days, he or she will document the rationale for extending the use and include the duration of the PRN order. - Residents and/or RP have the right to decline treatment with psychotropic medications		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure each resident in a nursing facility is screened for a mental disorder (MD - a medical condition that affects how you think, feel, and behave) or intellectual disability (ID - a lifelong condition that begins in childhood, characterized by significantly below-average intelligence and major difficulties managing everyday life skills, communication, and self-care) prior to admission and that individuals identified with MD or ID are evaluated and receive care and services in the most integrated setting for three of five sampled residents (Residents 42, 7, and 9) by failing to ensure the facility: 1. Performed a Preadmission Screening and Resident Review (PASRR - a mandatory federal screening process designed to ensure people with mental illnesses or developmental disabilities (DD) are not inappropriately placed in nursing homes and receive the right care) assessment for Resident 42 when the resident was newly diagnosed with dementia (a progressive state of decline in mental abilities), depression (a common, serious mental health condition characterized by persistent sadness, loss of interest in activities, and an inability to experience joy), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and generalized anxiety disorder (GAD - a mental health condition characterized by constant, excessive, and uncontrollable worry about everyday life events [like work, health, or finances] that lasts for at least six months). 2. Performed a PASRR assessment for Resident 7 when the resident was newly diagnosed with psychosis, GAD, and depression. 3. Submitted a new PASRR Level I Screening for Resident 9 when the resident had a discrepancy in the previous PASRR Level I Screening. These deficient practices had the potential for delayed care and services in the most integrated setting appropriate for individuals identified with MD or ID. Findings: 1. During a review of Resident 42's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident on 1/27/2026, and readmitted the resident on 5/2/2026, with diagnoses including GAD (4/27/2026), depression (4/27/2026), and psychosis (4/27/2026). During a review of Resident 42's History and Physical (H&P), dated 1/28/2026, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS - a resident assessment tool), dated 4/28/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had severe cognitive impairment (a serious decline in mental abilities&mdash;like memory, reasoning, and judgment&mdash;that is severe enough to destroy a person's independence). The MDS indicated that the resident was on a high-risk drug class antipsychotic (a class of prescription medications primarily used to manage symptoms of psychosis, such as hallucinations [seeing or hearing things that aren't there] and delusions [false, fixed beliefs]) and antidepressant medications (a commonly prescribed medication to treat depression and other mental health conditions). The MDS indicated that the resident had a family who participated in the assessment and goal setting of the resident's care. During a review of Resident 42's PASRR, dated 1/26/2026, the PASRR indicated unable to complete level II evaluation for serious mental illness (SMI). The individual has no SMI and no functional limitations in last 6 months. During a concurrent interview and record review on 5/20/2026 at 11:03 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 42's AR and PASRR were reviewed. The MDS stated the resident had new diagnoses of GAD (4/27/2026), depression (4/27/2026), and psychosis (4/27/2026). The MDSC stated that there should have been a resident review for the PASRR. The MDSC stated there was a potential for not providing mental, psychosocial services to the resident. The MDSC stated he (MDSC) was responsible for MDS screening for PASRR and he (MDSC) overlooked the resident's new diagnoses of mental illnesses. During an interview on 5/21/2026 at (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1:52 p.m. with the Director of Nursing (DON), the DON stated the MDSC should have performed another PASRR assessment for the new diagnoses of mental illnesses on the resident. The DON stated that it was the responsibility of the MDSC to ensure residents diagnosed with SMI were performed with PASRR assessments. The DON stated the failure of the MDSC to perform a PASRR screening on Resident 42 had the potential for delayed care and services needed for residents with SMI. 2. During a review of Resident 7's AR, the AR indicated the facility admitted the resident on 10/18/2024, and readmitted the resident on 2/2/2025, with diagnoses of psychosis (2/25/2025), depression (2/25/2025), and GAD (2/25/2025). During a review of Resident 7's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and usually understand others and had moderate cognitive impairment (is the middle ground between normal forgetfulness and dementia). The MDS indicated the resident was on a high-risk drug class antidepressant medication. During a review of Resident 7's PASRR, dated 10/17/2024, the PASRR indicated a level II mental health evaluation is not required. During a concurrent interview and record review on 5/20/2026 at 11:50 a.m. with the MDSC, Resident 7's AR and PASRR was reviewed. The MDSC stated the resident had new diagnoses of psychosis (2/25/2025), depression (2/25/2025), and GAD (2/25/2025). The MDSC stated that there should have been a resident review for the PASRR. The MDSC stated there was a potential for not providing mental, psychosocial services to the resident. The MDSC stated he (MDSC) was responsible for MDS screening for PASRR and he (MDSC) overlooked the resident's new diagnoses of mental illnesses. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated the MDSC should have performed another PASRR assessment for the new diagnoses of mental illnesses on the resident. The DON stated that it was the responsibility of the MDSC to ensure residents diagnosed with SMI were performed with PASRR assessments. The DON stated the failure of the MDSC to perform a PASRR screening on Resident 7 had the potential for delayed care and services needed for residents with SMI. During a review of the facility's recent policy and procedure (P&P) titled, Pre-admission Screening and Resident Review (PASSR), last reviewed on 4/23/2026, the P&P indicated . all residents will be screened on admission and annually thereafter. Figure 4: Sample Level I Screening Section III (continued) indicated under Diagnosed Mental Illness 10. Does the individual have a serious diagnosed mental disorder such as Depressive Disorder, Anxiety Disorder.? 3. During a review of Resident 9's AR, the AR indicated the facility admitted the resident on 3/31/2026 with diagnoses including alcohol abuse, GAD, and major depressive disorder. During a review of Resident 9's H&P, dated 4/1/2026, the H&P indicated Resident 9 had the capacity to understand and make decisions. The H&P further indicated that Resident 9 had anxiety and depression. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 the resident diagnosis including major depressive disorder and GAD and was taking psychotropic medications. During a review of Resident 9's PASRR Level I Screening, dated 3/31/2026, the PASRR Level I Screening under section III question number 10 indicated that the resident did not have a serious diagnosed mental disorder, no suspected mental illness, and has not been prescribed psychotropic (medications capable of affecting the mind, emotions, and behavior) medications. During a concurrent interview and record review on 5/20/2026 at 11:04 a.m. with the MDSC, Resident 9's AR, MDS, H&P, and PASRR Level I Screening, dated 3/31/2026, were reviewed. The MDSC stated Resident 9's AR and H&P indicated that Resident 9 had a diagnosis of including major depressive disorder and GAD upon admission and that Resident 9's PASRR Level I Screening indicated that the resident did not have a SMI/ID/DD/RC (related condition) and did not require a Level II Screening. The MDSC stated prior to a resident's admission to the facility, the acute hospital was responsible in ensuring the Level I Screening was completed, then the MDSC will verify the accuracy of the screening. The MDSC further stated if there was a discrepancy, he (MDSC) would then resubmit a new Level I Screening reflecting the resident's current diagnosis. The MDSC stated that he (MDSC) (continued on next page)		

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

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should have resubmitted Resident 9's Level I Screening to reflect that the resident had major depressive disorder and GAD upon admission. The MDSC stated that if there was no new Level 1 Screening submitted, the resident would not be evaluated and would not receive the appropriate treatment and referral as needed. The MDSC stated it could result in a delay of care and services Resident 9 needed. During an interview on 5/21/2026 at 2:48 p.m. with the DON, the DON stated the MDSC was responsible for ensuring that the PASRR Level I Screening is accurate upon admission and resubmit a new Level I Screening if there was a discrepancy. The DON stated that the purpose of the PASRR was to ensure that all the residents admitted in the facility will receive the proper mental health evaluation, services, and interventions needed. The DON stated that the MDSC should have resubmitted a new Level I Screening for Resident 9 if the resident met the criteria for an SMI. The DON stated if a new Level I Screening was not resubmitted, Resident 9 will not be evaluated properly, which could lead to a delay in the interventions and services the resident needed. During a review of the facility's P&P titled, Pre-admission Screening and Resident Review (PASSR), last reviewed on 4/23/2026, the P&P indicated all residents will be screened on admission and annually thereafter to ensure that all residents are screened for mental illness and/or ID prior to admission and to ensure this assessment effort is coordinated with the appropriate state agencies if indicated. PASRR is a federal requirement to help ensure that individuals who have a mental disorder or ID are not inappropriately placed in nursing homes for long term care. The P&P further indicated for completion of Level I Screening under section III question number 10, the diagnosed mental disorders include depressive disorder, anxiety disorder and question number 12 indicated if the individual has been prescribed psychotropic medications for mental illness.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for two of five sampled residents (Residents 11 and 46) reviewed for unnecessary medications by failing to ensure the facility developed and implemented a care plan for: 1. Resident 11's use of Xarelto (a prescription blood thinner). 2. Resident 46's use of psychotropic medications (any medication that alters brain function, thereby changing a person's mood, thoughts, feelings, or behavior) Alprazolam (a fast-acting prescription tranquilizer [best known by the brand name Xanax] used to quickly calm the nervous system) and Aripiprazole (acts as a brain stabilizer that helps regulate mood, thoughts, and behaviors by balancing key chemicals in the brain). The deficient practices had the potential to result in a delay of nursing care and medical interventions for the residents. Findings: 1. During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted the resident on 8/31/2016, and readmitted the resident on 4/2/2024, with diagnoses including peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), atherosclerotic heart disease (happens when sticky, fatty deposits called plaque buildup inside the arteries that supply blood to the heart), and peptic ulcer (an open sore or raw spot that develops on the inside lining of the stomach or the very first part of the small intestine). During a review of Resident 11's History and Physical (H&P), dated 4/18/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 4/1/2026, the MDS indicated the resident had the ability to make self-understood and usually had the ability to understand others and had moderate cognitive impairment (an intermediate state of brain decline where memory and thinking problems are noticeable to others and affect complex daily tasks (like managing finances or medications), but the person remains mostly independent with basic daily self-care like eating and bathing). The MDS indicated the resident was on a high-risk drug class anticoagulant (a medication that prevents blood from clotting too easily, earning it the common nickname blood thinner). During a review of Resident 11's Order Summary Report (OSR), dated 4/18/2026, the OSR indicated an order for Xarelto Oral Tablet 10 milligrams (mg, a unit of weight) (Rivaroxaban). Give one tablet by mouth one time a day for cerebrovascular accident prophylaxis (CVA PPX, a medical term for taking steps to prevent a stroke) During a concurrent interview and record review on 5/20/2026, at 11:40 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 11's OSR and Care Plans were reviewed. The MDSC stated there was no care plan developed and implemented addressing Resident 11's use of Xarelto. The MDSC stated the care plan was important to ensure safe use of Xarelto. The MDSC stated the care plan serves as a communication tool to all healthcare providers to ensure the use of Xarelto was monitored for adverse effects (any unwanted, unintended, or harmful result of a medical treatment, such as a prescription drug, surgery, or therapy) and to ensure the interventions were provided constantly to meet the set goals. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated it was important for Resident 11 to have a care plan for the use of Xarelto to ensure its safe use. The DON stated the care plan serves as a communication tool to all healthcare disciplines on what the goal of therapy was and what interventions were set to meet the goal. The DON stated the number one goal of anticoagulant therapy was to prevent bleeding to residents. The DON stated the failure of the licensed staff to develop and implement a care plan on the use of Xarelto had predisposed the resident to its unsafe use and possibly bleeding. 2. During a review of Resident 46's AR, the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including mood disorder (is a type of mental health condition where there is a disconnect between actual life circumstances and the person's state of mind or feeling), generalized anxiety (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder (GAD, a mental health condition characterized by constant, excessive, and uncontrollable worry about everyday life events (like work, health, or finances) that lasts for at least six months), and alcohol dependence (a chronic, relapsing disease where a person develops an uncontrollable physical and psychological reliance on alcohol). During a review of Resident 46's H&P, dated 4/11/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 46's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment. The MDS indicated the resident was on a high-risk drug class antipsychotic (prescription medications used primarily to manage conditions that involve psychosis) and antianxiety medications (prescription drugs designed to calm the brain, relax muscles, and reduce feelings of extreme fear, worry, and panic). During a review of Resident 46's OSR, the OSR indicated an order for: 4/30/2026 Alprazolam Oral Tablet 0.5 mg (Alprazolam). Give one tablet by mouth every six hours as needed for anxiety monitor for behavior (m/b) constant complaints of pain for 30 Days. 4/10/2026 Aripiprazole Oral Tablet 5 mg (Aripiprazole). Give one tablet by mouth at bedtime for Mood disorder m/b paranoia (an intense, irrational feeling of distrust and suspicion) as evidenced by (aeb) persistent unrealistic fear. During a concurrent interview and record review on 5/20/2026, at 3:41 p.m., with the MDSC, Resident 46's OSR and CPs were reviewed. The MDSC stated there was no care plan addressing Resident 46's use of Alprazolam and Aripiprazole. The MDSC stated the failure of the licensed staff to develop and implement a care plan on the use of psychotropic medications Alprazolam and Aripiprazole on Resident 46 had predisposed the resident to its adverse effects and uncoordinated care among healthcare providers. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated it was important for Resident 46 to have a care plan for the use of psychotropic medication Alprazolam and Aripiprazole to ensure its safe use. The DON stated the care plan serves as a communication tool to all healthcare disciplines on what the goal of therapy was and what interventions were set to meet the goal. The DON stated the number one goal of psychotropic medication therapy was to manage and reduce distressing mental health symptoms by altering brain chemistry. The DON stated the failure of the licensed staff to develop and implement a care plan on the use of Alprazolam and Aripiprazole had predisposed the resident to its unsafe use and possibly sedation and mental and psychological decline. During a review of the facility's recent policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/23/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the comprehensive care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs for three of three sampled residents (Residents 42, 5, and 71) reviewed for pressure injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to review and revise the fall care plan of the resident to reflect the resident's use of low air loss mattress (LALM, a medical bed that slowly pumps continuous air through tiny, microscopic holes in its surface). The deficient practice had the potential for delayed and unnecessary care for residents. Cross reference F686. Findings: 1. During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted the resident on 1/27/2026, and readmitted the resident on 5/2/2026, with diagnoses including sepsis (a life-threatening blood infection), acute respiratory failure (a life-threatening medical emergency where your lungs suddenly cannot get enough oxygen into your blood or fail to remove enough carbon dioxide), and malignant neoplasm of the bone (it is an aggressive, uncontrolled growth of abnormal cells that forms a destructive tumor in the bone tissue). During a review of Resident 42's History and Physical (H&P), dated 1/28/2026, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 4/28/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understands others and had severe cognitive impairment (a person has lost their mental capacity to the point where they can no longer live independently, make basic decisions, or safely care for themselves). The MDS indicated the resident was dependent to needing substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a stage 3 pressure injury (full-thickness loss of skin. Dead and black tissue may be visible) over a bony prominence and was at risk for developing further pressure injuries and was on pressure reducing device for bed and on pressure ulcer/injury care. During a review of Resident 42's Order Summary Report (OSR), dated 5/13/2026, the OSR indicated an order for low air loss mattress for wound management. During a review of Resident 42's Care Plan (CP) Report titled, The resident has stage three (3) pressure ulcer (Sacro coccyx, refers to the area where your lower back meets your tailbone) or potential pressure ulcer development. last revised on 5/12/2026, the CP did not include LALM as an intervention. During a concurrent observation and interview on 5/18/2026, at 9:54 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 42's room, observed Resident 42 had a low air loss mattress on. LVN 1 stated the LALM was needed as an intervention for pressure ulcer management. During a concurrent interview and record review on 5/20/2026, at 11:10 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 42's MDS, OSR, and CPs were reviewed. The MDSC stated the LALM was not added to the current care plan titled, The resident has stage three pressure ulcer (Sacro coccyx) or potential pressure ulcer development. The MDSC stated the care plan should have been updated to reflect current treatment to ensure consistency in implementing treatment orders made by the physician. The MDSC stated the failure of the interdisciplinary team (IDT, is a collaborative group of different healthcare professionals who work together to create, carry out, and regularly update a personalized care and recovery plan for a patient or resident) to update the care plan with current physician order interventions had a potential for inconsistencies with care resulting to poor wound healing and development of further pressure injuries. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated Resident 42's care plan titled, The resident has stage three pressure ulcer (Sacro coccyx) or potential pressure ulcer (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave North Hollywood, CA 91606	
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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	development., should have been updated to reflect the physician's order for LALM. The DON stated the failure of the staff to update the care plan predisposed the resident for variation in care and services needed to treat the resident's pressure injury that can result to delay in treatment and possible worsening of pressure injuries. 2. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 1/26/2021, and readmitted the resident on 7/18/2025, with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), encephalopathy (any disease, damage, or malfunction of the brain that alters how it functions), and dysphagia (difficulty swallowing). During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitive impairment. The MDS indicated the resident was dependent to needing partial assistance on mobility and ADLs. The MDS indicated the resident had a stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness) over bony prominence and was at risk for developing further pressure injuries and was on pressure reducing devices for bed and on pressure injury care. During a review of Resident 5's OSR, dated 11/13/2025, the OSR indicated an order for low air loss mattress for wound management during every shift. During a review of Resident 5's Care Plan (CP) Report titled, The resident has stage three pressure injury Sacro coccyx extending to right buttocks., last revised on 5/13/2026, the CP did not include LALM as an intervention. During a concurrent observation and interview on 5/18/2026, at 9:27 a.m., with LVN 1, inside Resident 5's room, observed Resident 5 had a low air loss mattress on. LVN 1 stated the LALM was needed as an intervention for pressure ulcer management. During a concurrent interview and record review on 5/20/2026, at 11:33 a.m., with the MDSC, Resident 5's MDS, OSR, and CPs were reviewed. The MDSC stated the LALM was not added to the current care plan titled The resident has stage three pressure injury Sacro coccyx extending to right buttocks. The MDSC stated the care plan should have been updated to reflect current treatment to ensure consistency in implementing treatment orders made by the physician. The MDSC stated the failure of the IDT to update the care plan with current physician order interventions had a potential for inconsistencies with care resulting to poor wound healing and development of further pressure injuries. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated Resident 5's care plan titled, The resident has stage three pressure injury Sacro coccyx extending to right buttocks., should have been updated to reflect the physician's order for LALM. The DON stated the failure of the staff to update the care plan predisposed the resident for variation in care and services needed to treat the resident's pressure injury that can result to delay in treatment and possible worsening of pressure injuries. 3. During a review of Resident 71's AR, the AR indicated the facility admitted the resident on 8/16/2024, and readmitted the resident on 10/20/2025, with diagnoses including fracture (break in bone) of neck and left femur (the single bone located in the upper leg between the hip and the knee), encephalopathy, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 71's History and Physical (H&P), dated 2/7/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and sometimes understands others and had severe cognitive impairment (a serious loss of mental capacity-such as reasoning, memory, and concentration-that prevents a person from living or taking care of themselves independently). The MDS indicated the resident was dependent to needing partial assistance on mobility and ADLs. The MDS indicated the resident was at risk for developing pressure injuries. During a review of Resident 71's OSR, dated 5/18/2026, the OSR indicated an order for low air loss mattress for wound management. During a review of Resident 71's CP Report titled, Documented pressure ulcer, initiated on 7/11/2025, the CP did not include LALM as an intervention. During a concurrent observation and interview on 5/18/2026, at 9:52 a.m., with LVN 1, inside Resident 71's room, observed Resident 71 had a low air loss mattress on. LVN 1 stated the (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LALM was needed as an intervention for pressure ulcer prevention. During a concurrent interview and record review on 5/20/2026, at 11:56 a.m., with the MDSC, Resident 71's MDS, OSR, and CPs were reviewed. The MDSC stated the LALM was not added to the current care plan titled Documented pressure ulcer. The MDSC stated the care plan should have been updated to reflect current treatment to ensure consistency in implementing treatment orders made by the physician. The MDSC stated the failure of the IDT to update the care plan with current physician order interventions had a potential for inconsistencies with care resulting to poor wound healing and development of further pressure injuries. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated Resident 71's care plan titled, Documented pressure ulcer, should have been updated to reflect the physician's order for LALM. The DON stated the failure of the staff to update the care plan predisposed the resident for variation in care and services needed to treat the resident's pressure injury that can result to delay in treatment and possible worsening of pressure injuries. During a review of the facility's recent policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/23/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment.		

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers/injury (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing for three of three sampled residents (Residents 42, 5, and 71) reviewed under pressure ulcer/injury by failing to ensure the low air loss mattress (LALM, a specialized bed mattress that helps prevent and treat pressure ulcers [bedsores] by using a continuous flow of air to regulate temperature and moisture on the skin) of the residents were set according to the residents' weight. The deficient practices had the potential for worsening of pressure injury to residents. Cross reference F657. Findings: 1. During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted the resident on 1/27/2026, and readmitted the resident on 5/2/2026, with diagnoses including sepsis (a life-threatening blood infection), acute respiratory failure (a life-threatening medical emergency where the lungs suddenly cannot get enough oxygen into the blood or fail to remove enough carbon dioxide), and malignant neoplasm of the bone (a cancerous tumor that grows in the bones or cartilage). During a review of Resident 42's History and Physical (H&P), dated 1/28/2026, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 4/28/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understands others and had severe cognitive impairment (a person has lost the ability to think, remember, and make decisions to the point that they cannot live independently or take care of themselves). The MDS indicated the resident was dependent to needing substantial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a stage 3 pressure injury (full-thickness loss of skin. Dead and black tissue may be visible) over a bony prominence and was at risk for developing further pressure injuries and was on pressure reducing device for bed and on pressure ulcer/injury care. During a review of Resident 42's Order Summary Report (OSR), dated 5/13/2026, the OSR indicated an order for low air loss mattress for wound management. During a review of Resident 42's Care Plan (CP) Report titled, The resident has stage three pressure ulcer (Sacro coccyx, refers to the connection between two specific bones at the very bottom of the spine: the sacrum (the large, triangular bone wedged between the hip bones) and the coccyx (the tailbone) or potential pressure ulcer development. last revised on 5/12/2026, the CP did not include LALM as an intervention. During a review of Resident 42's Braden Scale for Predicting Pressure Ulcer Risk Evaluation (BS), dated 5/16/2026, the BS indicated the resident was at high risk for developing pressure injuries. During a review of Resident 42's Weights and Vitals Log (WVL), dated 5/11/2026, the WVL indicated the resident's current weight was 146 pounds (lbs., a unit of weight). During a concurrent observation and interview on 5/18/2026, at 9:54 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 42's room, observed Resident 42 had a low air loss was set past 350 on the machine. LVN 1 stated the LALM should be set according to the resident's weight. During a concurrent interview and record review on 5/20/2026, at 11:10 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 42's MDS, OSR, BS, WVL, and CPs were reviewed. The MDSC stated the LALM of Resident 42 should have been set according to the resident's weight. The MDSC stated the current weight of the resident was 146 lbs. The MDSC stated the failure of the staff to set the bed according to the resident's weight had a potential for worsening of the pressure ulcer of the resident on the Sacro coccyx area. The MDSC stated the current care plan titled, The resident has stage three pressure ulcer (Sacro coccyx) or potential pressure ulcer development. The MDSC stated the care plan should have been updated to reflect current treatment to ensure consistency in implementing treatment orders made by the physician. The MDSC stated the failure of the (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interdisciplinary team (IDT, a collaborative care conference where healthcare professionals, the resident, and their family gather to review the resident's health, discuss goals, and update the individualized care plan) to update the care plan with current physician order interventions had a potential for inconsistencies with care resulting to poor wound healing and development of further pressure injuries. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated Resident 42's LALM should have been set according to the resident's current weight. The DON stated the care plan titled, The resident has stage three pressure ulcer (Sacro coccyx) or potential pressure ulcer development., should have been updated to reflect the physician's order for LALM. The DON stated the failure of the staff to set the LALM according to the resident's weight and update the care plan predisposed the resident for variation in care and services needed to treat the resident's pressure injury that can result to delay in treatment and possible worsening of pressure injuries. 2. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 1/26/2021, and readmitted the resident on 7/18/2025, with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), encephalopathy (any disease, damage, or malfunction of the brain that alters how it functions), and dysphagia (difficulty swallowing). During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitive impairment. The MDS indicated the resident was dependent to needing partial assistance on mobility and ADLs. The MDS indicated the resident had a stage 1 pressure injury (intact skin with a localized area of redness and/or changes in sensation, temperature, or firmness) over bony prominence and was at risk for developing further pressure injuries and was on pressure reducing devices for bed and on pressure injury care. During a review of Resident 5's OSR, dated 11/13/2025, the OSR indicated an order for low air loss mattress for wound management. Every shift. During a review of Resident 5's BS, dated 3/25/2026, the BS indicated the resident was very high risk for developing pressure injuries. During a review of Resident 5's WV, dated 5/4/2026, the WV indicated the resident's current weight was 124 lbs. During a review of Resident 5's Care Plan (CP) Report titled, The resident has stage three pressure injury Sacro coccyx extending to right buttocks., last revised on 5/13/2026, the CP did not include LALM as an intervention. During a concurrent observation and interview on 5/18/2026, at 9:27 a.m., with LVN 1, inside Resident 5's room, observed Resident 5's low air loss mattress was set to 300 and static. LVN 1 stated the LALM should be set according to the resident's weight. During a concurrent interview and record review on 5/20/2026, at 11:33 a.m., with the MDSC, Resident 5's MDS, OSR, and CPs were reviewed. The MDSC stated the LALM of Resident 5 should have been set according to the resident's weight. The MDSC stated the current weight of the resident was 124 lbs. The MDSC stated the failure of the staff to set the bed according to the resident's weight had a potential for worsening of the pressure ulcer of the resident on the Sacro coccyx area. The MDSC stated the LALM was not added to the current care plan titled The resident has stage 3 pressure injury Sacro coccyx extending to right buttocks. The MDSC stated the care plan should have been updated to reflect current treatment to ensure consistency in implementing treatment orders made by the physician. The MDSC stated the failure of the IDT to update the care plan with current physician order interventions had a potential for inconsistencies with care resulting to poor wound healing and development of further pressure injuries. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated Resident 5's LALM should have been set according to the resident's current weight. The DON stated Resident 5's care plan titled, The resident has stage three pressure injury Sacro coccyx extending to right buttocks., should have been updated to reflect the physician's order for LALM. The DON stated the failure of the staff to update the care plan predisposed the resident for variation in care and services needed to treat the resident's pressure injury that can result to delay in treatment and possible worsening of pressure injuries. 3. During a review of Resident 71's AR, the AR indicated the facility admitted the resident on 8/16/2024, and readmitted the resident on 10/20/2025, with diagnoses including fracture (break in bone) of neck (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and left femur (the medical name for the thigh bone), encephalopathy, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 71's H&P, dated 2/7/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and sometimes understands others and had severe cognitive impairment. The MDS indicated the resident was dependent to needing partial assistance on mobility and ADLs. The MDS indicated the resident was at risk for developing pressure injuries. During a review of Resident 71's BS, dated 4/23/2026, the BS indicated the resident was very high risk for developing pressure injuries. During a review of Resident 71's OSR, dated 5/18/2026, the OSR indicated an order for low air loss mattress for wound management. During a review of Resident 71's WV, dated 5/6/2026, the WV indicated the resident's current weight was 118 lbs. During a review of Resident 71's CP Report titled, Documented pressure ulcer, initiated on 7/11/2025, the CP did not include LALM as an intervention. During a concurrent observation and interview on 5/18/2026, at 9:52 a.m., with LVN 1, inside Resident 71's room, observed Resident 71 had a low air loss mattress was set at 250, alternating. LVN 1 stated the LALM should be set according to the resident's weight. During a concurrent interview and record review on 5/20/2026, at 11:56 a.m., with the MDSC, Resident 71's MDS, OSR, and CPs were reviewed. The MDSC stated the LALM of Resident 71 should have been set according to the resident's weight. The MDSC stated the current weight of the resident was 118 lbs. The MDSC stated the failure of the staff to set the bed according to the resident's weight had a potential for development of pressure ulcer on the resident. The LALM was not added to the current care plan titled Documented pressure ulcer. The MDSC stated the care plan should have been updated to reflect current treatment to ensure consistency in implementing treatment orders made by the physician. The MDSC stated the failure of the IDT to update the care plan with current physician order interventions had a potential for inconsistencies with care resulting to poor wound healing and development of further pressure injuries. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated Resident 71's LALM should have been set according to the resident's current weight. The DON stated Resident 71's care plan titled, Documented pressure ulcer, should have been updated to reflect the physician's order for LALM. The DON stated the failure of the staff to update the care plan predisposed the resident for variation in care and services needed to treat the resident's pressure injury that can result to delay in treatment and possible worsening of pressure injuries. During a review of the facility's recent policy and procedure (P&P) titled, Prevention of Pressure Injuries, last reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to provide information regarding identification of pressure injury risk factors and interventions for specific risk factors. Support Surfaces and Pressure Redistribution 1. Select appropriate support surfaces based on the resident's risk factors, in accordance with current clinical practice. During a review of the facility's recent P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/23/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 12. The interdisciplinary team reviews and updates the care plan: a. when there has been significant change in the resident's condition; b. when the desired outcome is not met; c. when the resident has been readmitted to the facility from hospital stay; and d. at least quarterly, in conjunction with the required quarterly MDS assessment. During a review of the facility-provided Low Air Loss Mattress (LALM) 1 Replacement System Operator's Manual, undated, the OM indicated under Product (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Functions: Pressure-adjust Knob (2) Determine the patient's weight and set the control knob to that weight setting on the control unit.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for three (3) of five (5) sampled residents (Resident 1, 34, and 71) reviewed for environment task by failing to ensure the floor mats (a cushioned floor pad designed to help prevent injury should a person fall) did not have equipment or furniture on top of them. The deficient practices increase the risk of accidents such as falls with injuries, poisoning, and electrocution on residents. Findings: 1. During a review of Resident 1's admission Record (AR), indicated the facility admitted the resident on 4/1/2026, with diagnoses including metabolic encephalopathy (confusion or changes in thinking caused by a medical problem in the body); type 2 diabetes mellitus with other circulatory complications (a disorder characterized by difficulty in blood sugar control that has caused blood circulation problems); lack of coordination (trouble with balance or movement). During a review of Resident 1's History and Physical (H&P), dated 4/2/2026, the H&P indicated that the resident did not have the capacity to make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2026, the MDS indicated the resident had the ability to usually make self-understood and usually understand others and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated that the resident was dependent or required partial/moderate assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 5/18/2026, at 11:20 a.m., with Certified Nurse Assistant (CNA) 6, inside Resident 1's room, observed Resident 1's bedside table and nightstand on top of the floor mat. CNA 6 stated that floor mat would not serve its purpose in the event of Resident 1's fall the table and nightstand would cause more injury to the resident. During an interview on 5/20/2026, at 11:51 a.m., with the Minimum Data Set Coordinator (MDSC), the MDSC stated the purpose of the floor mat was to provide a soft landing surface for residents in the event of a fall; however, by placing furniture or equipment on top of the mat it defeats its purpose potentially causing injury with fracture due to the hard objects on top of the floor mat. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated the floor mat of Resident 1 should have no equipment or furniture on top of them to prevent falls with injuries. The DON stated that the floor mat serves as a soft-landing mat to prevent the resident from sustaining injuries such as fractures. The DON stated that staff's failure to keep objects off the floor mat increased the resident's risk for falls and injuries. 2. During a review of Resident 34's AR, the AR indicated the facility admitted the resident on 2/15/2019, and readmitted on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (A stroke (blocked blood flow in the brain) caused damage in the brain, leading to either weakness or complete loss of movement on the left side of the body); other lack of coordination (trouble with balance or movement); contracture, left hand (the left hand has become tight or stiff, making it hard to straighten or move the hand (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	normally). During a review of Resident 34's H&P, dated 1/31/2026, the H&P indicated that the resident did not have the capacity to understand and make decisions. During a review of Resident 34's MDS dated [DATE], the MDS indicated the resident had the ability to usually make self-understood and understand others and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated the resident was dependent or required moderate assistance on mobility and activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an observation and interview on 5/18/2026, at 9:55 a.m., with Certified Nurse Assistant (CNA) 5 inside Resident 34's room, the resident was observed lying in bed and bedside table was on top of the floor mat to the right side and the top part of the left floor mat was under the bed. CNA 5 stated there should be no furniture placed on the floor mat. During an interview on 5/20/2026, at 11:51 a.m., with the MDSC, the MDSC stated the purpose of the floor mat was to provide a soft landing surface for residents in the event of a fall; however, by placing furniture or equipment on top of the mat it defeats its purpose potentially causing injury with fracture due to the hard objects on top of the floor mat. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated the floor mat of Resident 34 should have no equipment or furniture on top of them to prevent falls with injuries. The DON stated that the floor mat serves as a soft-landing mat to prevent the resident from sustaining injuries such as fractures. The DON stated that staff's failure to keep objects off the floor mat increased the resident's risk for falls and injuries. 3. During a review of Resident 71's AR, the AR indicated the facility admitted the resident on 8/16/2024, and readmitted the resident on 10/20/2025, with diagnoses including fracture (break in bone) of neck and left femur (is the single, thick bone in the upper leg that connects the hip to the knee), encephalopathy (any disease, damage, or malfunction of the brain that alters how it functions), and epilepsy (a chronic brain disorder characterized by recurring, unprovoked seizures). During a review of Resident 71's H&P, dated 2/7/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and sometimes had the ability to understand others and had severe cognitive impairment (a person has lost the ability to think, remember, or make decisions to the point that they cannot live independently or care for themselves). The MDS indicated the resident was dependent to needing partial assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated that the resident had a fall since admission/entry or reentry prior to assessment with injury. During a review of Resident 71's Order Summary Report, dated 5/20/2026, the OSR did not indicate an order for floor mat. During a review of Resident 71's Fall Risk Evaluation (FRE), dated 5/10/2026, the FRE indicated the resident was at risk for falls. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 71's Care Plan (CP) Report titled, Resident at risk for alteration in neurological status related to diagnosis of encephalopathy, epilepsy., last revised on 3/19/2026, the CP indicated an intervention of if seizure activity occurs, placed on side, maintain open airway. Remove obstacles to ensure safe environment. During a concurrent observation and interview on 5/18/2026, with Licensed Vocational Nurse (LVN) 1, inside Resident 71's room, observed Resident 71's floor mat at the right side of the bed with an intravenous (IV, within a vein) pole for feeding pump on top of the floor mat. LVN 1 stated there should be no equipment or furniture on top of the floor mat as when the resident accidentally slid over the bed the resident with fall on the hard equipment or furniture on top of the floor mat causing injury to the resident. LVN 1 stated placing objects on top of the floor mat defeats the purpose of the mat to provide a safe, soft-landing surface for the resident. LVN 1 stated the failure of the staff to keep the floor mat free from equipment or furniture on top of the mat had predisposed the resident to fall with injury such as fractures. During a concurrent interview and record review on 5/20/2026, at 11:51 a.m., with the MDSC, Resident 71's OSR, FRE, and CPs were reviewed. The MDSC stated the resident was high risk for falls and there was no order for floor mat on the resident. The MDSC stated the floor mat does not need an order because they use it as an intervention to residents who had histories of fall in the facility to reduce the risk of injury. The MDSC stated the purpose of the floor mat was to provide a soft-landing surface for residents when they fall, however, if there were furniture or equipment on top of the mat it defeats its purpose and can cause injury with fracture due to the hard objects on top of them. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated the floor mat of Resident 71 should have no equipment or furniture on top of them to prevent fall with injuries on residents. The DON stated that the floor mat serves as a soft-landing mat to prevent the resident from incurring injuries such as fractures. The DON stated the failure of the staff to keep objects on top of the floor mat had predisposed the resident to falls with injuries. During a review of the facility's recent policy and procedure (P&P) titled, Safety and Supervision of Residents, last reviewed on 4/23/2026, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Facility-Oriented Approach to Safety 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting process: QAPI reviews of safety and incident/accident data, and a facility-wide commitment to safety at all levels of the organization. Individualized, Resident-Centered Approach to Safety 3. The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices. During a review of the facility's recent P&P titled, Falls and Fall Risk, Managing, last reviewed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on4/23/2026, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.^ Fall Risk Factors^ 1.Environmental factors that contribute to the risk of falls include:^ d. obstacles in the footpath.^ During a review of the facility-provided^Floor Mat (FM) 1^User Instructions^(UI), undated, the UI^indicated^when used as a^component^of a comprehensive fall prevention program, the^FM 1^reduces the impact of a fall from bed to help minimize injury.^		

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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, the facility failed to ensure residents with urinary catheters (a thin, flexible, hollow tube inserted into the bladder to drain urine when a person cannot urinate normally) received proper care and services for three of four sampled residents (Residents 42, 5, and 1) reviewed for urinary catheter or urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to ensure: 1. Resident 42's urinary catheter did not have loops and was not touching the floor. The loop had urine on them with sediments (a substance settling at the bottom of a liquid). 2. Residents 5 and 1's urinary catheter had a leg strap (a portable, handheld container designed to collect urine when a person cannot get to the bathroom) or stat lock (a specialized, adhesive device used in hospitals to securely hold a catheter tube in place on a patient's skin) on them. The deficient practices had the potential to result in trauma to residents' urinary catheter insertion site, dislodgement and/or removal of the urinary catheter, and increased risk for catheter-associated UTI. Findings: 1. During a review of Resident 42's admission Record (AR), the AR indicated the facility admitted the resident on 1/27/2026, and readmitted the resident on 5/2/2026, with diagnoses including sepsis (a life-threatening blood infection), urinary tract infection, and acute cystitis (a sudden bladder infection) and hematuria (having blood in the urine (pee)). During a review of Resident 42's History and Physical (H&P), dated 1/28/2026, the H&P indicated the resident had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated 4/28/2026, the MDS indicated the resident usually had the ability to make self-understood and usually understands others and had severe cognitive impairment (an individual has largely lost the ability to think, remember, reason, or learn). The MDS indicated the resident was dependent on toileting hygiene. During a review of Resident 42's Order Summary Report (OSR), the OSR indicated an order for: 5/5/2026 Urinary Catheter Care once daily (QD). Every day shift. 5/4/2026 Maintain catheter bag below bladder at all times and secure with stabilization device. Every shift. During a review of Resident 42's Care Plan (CP) Report titled, The resident has (Indwelling 16 French (Fr, a unit of measurement used to describe the outer diameter (thickness) of the catheter tube)/10 cubic centimeters (cc, a metric unit of volume that measures the amount of space inside a tiny cube) Catheter: infection UTI, last revised on 5/4/2026, the CP indicated an intervention to check tubing for kinks (twists) each shift. During a concurrent observation and interview on 5/18/2026, at 9:54 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 42's room, observed Resident 42's urinary catheter with loop and the catheter was touching the floor. The loop on the catheter had urine and sediments on them. LVN 1 stated the catheter tubing should be free flowing, the urine should freely drain to the collection bag to (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevent backflow of urine and infection. LVN 1 also stated the catheter tubing should not be touching the floor to prevent infection. During an interview and record review on 5/20/2026, at 11:16 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 42's OSR and CPs were reviewed. The MDSC stated Resident 42's catheter tubing should not have loops, and the urine should go directly to the bag. The MDSC stated the failure of the staff to ensure there were no loops on the urinary catheter had the potential for UTI due to possible existing urine to backflow to the bladder. The MDSC stated the CP titled, The resident has (Indwelling 16fr/10cc) Catheter: infection UTI, was not followed and the P&P titled, Catheter Care, Urinary, was not followed. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated Resident 42 should not have loops on the catheter tubing and the tubing should not be touching the floor due to ascending infection (a type of infection where bacteria or other germs travel upward from the lower parts of the body (such as the vagina or urethra) to higher, usually sterile, areas (such as the bladder, uterus, or kidneys). The DON stated the failure of the staff to ensure there were no loops on the urinary catheter tubing had predisposed the resident to UTI. 2. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 1/26/2021, and readmitted the resident on 7/18/2025, with diagnoses including type two diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), obstructive and reflux uropathy (is a blockage in the urinary system that stops pee from flowing out of the body), and encephalopathy (any disease, damage, or malfunction of the brain that alters how it functions). During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitive impairment. The MDS indicated that the resident needed substantial assistance on toileting hygiene. During a review of Resident 5's OSR, dated 4/8/2026, the OSR indicated an order for Urinary Catheter: Check anchor placement. Every shift. During a review of Resident 5's CP Report titled, The resident has foley catheter (a thin, flexible rubber or plastic tube that a doctor inserts into the bladder to drain urine) due to urinary retention (the inability to completely empty the bladder), last revised on 11/12/2025, the CP indicated a goal of the resident will be/remain free from catheter-related trauma through review date. During a concurrent observation and interview on 5/18/2026, at 9:45 a.m., with LVN 1, inside Resident 5's room, observed Resident 5's urinary catheter did not have a leg strap or a stat lock on them. LVN 1 stated Resident 5's urinary catheter should have a leg strap or stat lock on them to prevent tugging and pulling on the catheter that can cause trauma to the resident's meatus. During a concurrent interview and record review on 5/20/2026, at 11:34 a.m., with the MDSC, Resident 5's OSR and CPs were reviewed. The MDSC stated Resident 5's urinary catheter should have a securement device in place such as a leg strap or a stat lock to prevent the catheter from pulling and tugging causing trauma to the resident's meatus that can be a portal of entry for infection to set in. The MDSC stated the staff did not follow the physician's order to check anchor placement to catheter and the policy and procedure (P&P) titled, Catheter Care, Urinary, was not followed. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated Resident 5's urinary catheter should always have a securement device in place to prevent tugging and pulling of the tube causing trauma to the meatus leading to infection. 3. During a review of Resident 1's AR, the AR indicated the facility admitted the resident on 4/1/2026, with diagnoses including metabolic encephalopathy (confusion or changes in thinking caused by a medical problem in the body); type 2 diabetes mellitus with other circulatory complications (a disorder characterized by difficulty in blood sugar control that has caused blood circulation problems); infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter (an infection and irritation caused by a urinary catheter and continues with treatment after the problem was already diagnosed). During a review of Resident 1's H&P, dated 4/2/2026, the H&P indicated that the resident did not have the capacity to make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident had the ability to usually make self-understood and usually understand others and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated that the resident was dependent to staff or required partial/moderate assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 5/18/2026, at 2:45 p.m., with Certified Nurse Assistant (CNA) 6, inside Resident 1's room, observed Resident 1 with a foley catheter that did not have a securement device such as a stat lock or leg strap. CNA 6 stated that Resident 1's indwelling catheter does not have a stat lock for foley catheter which prevents pulling. During an interview on 5/20/2026, at 11:35 a.m., with Minimum Data Set Coordinator (MDSC), the MDSC stated the stat lock securement device is used to prevent unnecessary pulling which can cause irritation and tearing in the urinary meatus (the small opening at the end of the urethra where urine exits the body) leading to infection such as UTI. The MDSC stated Resident 1's indwelling catheter did not have a securement device such as stat lock or leg strap. The MDSC stated that the staff did not follow the policy and procedure titled, Catheter Care, Urinary. During an interview on 5/21/2026, at 2:10 p.m., with the Director of Nursing (DON), the DON stated the indwelling urinary catheter of Resident 1 should have had a stat lock securement device to keep the catheter in place, for alignment, and to prevent tugging and pulling causing trauma to the meatus of the resident which can create a portal of entry for infection to set in. The DON stated that all staff are responsible for ensuring residents with foley catheter have a stat lock in place. During a review of the facility's recent P&P titled, Catheter Care, Urinary, last reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. General Guidelines 4. Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site. (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Control 2. Be sure the catheter tubing and drainage bag are kept off the floor. Steps in the Procedure 16. Secure catheter with catheter securement device. During a review of the facility's recent P&P titled, Indwelling (Foley) Catheter Insertion, Male Resident, last reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to provide guidelines for the aseptic insertion of an indwelling (Foley) urinary catheter in a male resident. 13. Insert the catheter: f. Secure catheter tubing and/or bag to resident with approved catheter securement device. During a review of the facility's recent P&P titled, Indwelling (Foley) Catheter Insertion, Female Resident, last reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to provide guidelines for the aseptic insertion of an indwelling (Foley) urinary catheter in a female resident.		

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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 proper documentation for peripherally inserted central catheter (PICC- is a long flexible tube placed in the arm that goes to a large vein near the heart to give medication or fluids for long time) line dressing for one (1) of one (1) sampled resident (Resident 80), as the resident's PICC dressing did not have date, time, and staff initials in accordance with facility policy and procedure. This deficient practice had the potential to affect proper monitoring of dressing changes and infection control practices. Finding: During a review of Resident 80's admission Record (AR), the AR indicated the facility admitted the resident on 5/13/2026, and readmitted on [DATE], with diagnoses including sepsis, unspecified organism (a serious body infection spreading through the blood stream, where the exact germ causing the infection is unknown); Lack of coordination (trouble with balance or movement); essential (primary) hypertension (high blood pressure with no known specific cause). During a review of Resident 80's History and Physical (H&P), dated 5/14/2026, the H&P indicated that the resident had the capacity to understand and make decisions. During a concurrent observation and interview on 5/18/2026, at 2:55 p.m., with Licensed Vocational Nurse (LVN) 4, inside Resident 80's room, observed that Resident 80 had a PICC line on right upper arm. LVN 4 stated the PICC line dressing did not have the date and time, or the staff initials. During an interview on 5/21/2026, at 10:40 a.m., with Registered Nurse (RN) 1, RN 1 stated that PICC dressing change should be done every seven days or as needed. RN 1 stated if the PICC dressing does not have date, time, and initials the dressing should be changed because staff would not be able to verify when it was changed. RN 1 stated that if dressing changes are missed then it increases the risk of infection. During an interview for Resident 80 on 5/21/2026, at 2:55 p.m., with the Director of Nursing (DON), the DON stated the PICC dressing needs to be changed every seven days or as needed to prevent infection. The DON stated if the PICC dressing does not have date, time, initials then the dressing needs to be changed immediately to prevent any infection or skin breakdown. During a review of the facility's policy and procedures (P&P) titled, Central Venous Catheter Care and Dressing Changes, last reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections that are associated with contaminated, loosened, soil, or wet dressings. Procedure to apply sterile dressing: e. Label with initials, date and time.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for six of six sampled residents (Residents 8, 42, 5, 50, 35, and 59) reviewed for respiratory care. The facility failed to ensure: 1. Resident 8's oxygen via nasal cannula (a lightweight, flexible plastic tube that delivers extra oxygen (supplemental oxygen) directly into the nostrils via two small, comfortable prongs) was changed per physician's order. 2. Resident 42's: a. Suction canister (is a temporary, secure storage container used in medical and clinical settings to collect bodily fluids (like blood, mucus, and saliva) that are extracted during surgeries, emergencies, or breathing treatments) was labeled with the name of the resident and the date it was last changed. b. Yankauer (a rigid, curved plastic wand attached to a vacuum tube) and suction tubing (is a flexible, hollow hose used in medical settings to connect a vacuum machine to a specialized tip or catheter with the main job to create a vacuum effect that safely removes unwanted bodily fluids-like mucus, saliva, blood, or vomit-from a patient's body) was labeled with the date they were last changed. c. Oxygen via nasal cannula was labeled with the date it was last changed. 3. Resident 5's oxygen via nasal cannula was changed per facility protocol and was not touching the floor. 4. Resident 50's drawer did not contain another resident's nebulizer mask (is a plastic, cup-like face mask that covers your nose and mouth. It attaches to a machine called a nebulizer, which turns liquid medicine into a fine mist) and tubing and was undated. 5. Resident 35's nasal cannula tubing and humidifier (a medical device that adds moisture to the pure, dry oxygen a person is breathing) did not indicate the last time it was changed. 6. Resident 59's nasal cannula tubing was not on the floor. These deficient practices had the potential for residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: 1. During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted the resident on 9/4/2025, with diagnoses including end stage renal disease (ESRD, (End Stage Renal Disease-irreversible kidney failure), dependence on renal dialysis (a life-sustaining medical treatment that acts as an artificial kidney), and hypertensive heart disease (any heart problem caused by long-term, unmanaged high blood pressure). During a review of Resident 8's History and Physical (H&P), dated 9/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool), dated 3/5/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (an intermediate stage of brain decline between normal aging and dementia). During a review of Resident 8's Order Summary Report (OSR), dated 3/4/2026, the OSR indicated an order for: 3/7/2026 Oxygen: Tubing and Humidifier (a medical device that attaches to an oxygen tank or concentrator to add moisture to pure oxygen before you breathe it) Change. Every night shift every Sat. 2/8/2026 Oxygen: Oxygen at 2 liters per minute (LPM, measures how fast your oxygen is delivered) via nasal cannula for shortness of breath (SOB) as needed (PRN). Every 8 hours as (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needed. During a concurrent observation and interview on 5/18/2026, at 9:45 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 8's room, observed Resident 8's nasal cannula tubing was stored inside a clear plastic bag dated 5/11/2026. LVN 1 stated the oxygen tubing via nasal cannula should have been changed on 5/9/2026 (Saturday) per physician's order to prevent respiratory infections to the resident. During a concurrent interview and record review on 5/20/2026, with the Minimum Data Set Coordinator (MDSC), Resident 8's AR, MDS, and OSR were reviewed. The MDSC stated the oxygen via nasal cannula tubing stored in a clear plastic bag dated 5/11/2026 should have been discarded and replaced with a new one. The MDSC stated the staff should have followed the physician's order to change the tubing every Saturday. The MDSC stated the staff should label the tubing with the date it was last changed and the clear plastic bag should be labeled with the resident's name and the date it was last changed to prevent respiratory infections to residents. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated the oxygen via nasal cannula tubing of Resident 8 should have been discarded and replaced with the new nasal cannula tubing with a label of the date it was last changed to know when to change them again. The DON stated that properly labeling and changing the oxygen tubing prevents the resident from developing respiratory infections caused by contaminated and old tubing used for longer periods of time. 2. During a review of Resident 42's AR, the AR indicated the facility admitted the resident on 1/27/2026, and readmitted the resident on 5/2/2026, with diagnoses including pneumonia (an infection/inflammation in the lungs), sepsis (a life-threatening blood infection), and acute respiratory failure (a life-threatening condition that occurs when fluid leaks from small blood vessels in the lungs and builds up in the air sacs (alveoli)) with hypoxia (a dangerous condition where the body's tissues and organs do not get enough oxygen to function properly). During a review of Resident 42's H&P, dated 1/28/2026, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and understand others and had severe cognitive impairment (an extreme loss of brain function that completely destroys a person's ability to live independently). During a review of Resident 42's OSR, dated 5/20/2026, the OSR did not indicate an order for oxygen therapy. During a review of Resident 42's CP Reports titled, Impaired gas exchange, initiated on 4/21/2026, and Resident had cough and congestion, last revised on 5/17/2026, indicated interventions to elevate the head of the bed (Fowler's/semi-Fowler's), administering oxygen therapy (nasal cannula/mask) as ordered, encourage deep breathing and cough techniques, monitor pulse oximetry (a painless, non-invasive test used to check your blood oxygen levels and heart rate), and reduce patient anxiety and to maintain a clear airway by encouraging resident to clear own secretions with effective coughing. If secretions cannot be cleared, suction as ordered/required to clear secretions. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/18/2026, at 9:54 a.m., with LVN 1, inside Resident 42's room, observed Resident 42 had a suction setup (is an assembly of equipment that acts like a powerful, safe vacuum) with the suction canister with liquid whitish secretions almost full with no label and a Yankauer with suction tubing attached to the suction set up without the date it was last changed, and the resident had an oxygen via nasal cannula on touching the floor not labeled with the date it was last changed. LVN 1 stated the suction canister should be labeled with the date it was last changed, the Yankauer with tubing should be labeled with the date it was last changed, they can place the date on the sleeve of the Yankauer wrapper, and the oxygen tubing should be stored on a clear plastic bag with the date it was last changed to prevent respiratory infections to resident. During an interview and record review on 5/20/2026, at 11:12 a.m., with the MDSC, Resident 42's MDS, OSR, and CP were reviewed. The MDSC stated there was no order for the oxygen therapy on the resident and the suction canister, Yankauer with suction tubing, and the oxygen via nasal cannula should be dated of when it was last changed to prevent respiratory infections to residents. The MDSC stated labeling the respiratory supplies ensures the facility was not using the supplies for more than a week. The MDSC stated the failure of the staff to label the respiratory supplies predisposed the residents to development of respiratory infections. During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated the suction canister, Yankauer with suction tubing, and the oxygen via nasal cannula tubing of Resident 42 should have been discarded and replaced with the new suction canister, Yankauer with suction tubing, and nasal cannula tubing with a label of the date it was last changed to know when to change them again. The DON stated that properly labeling the respiratory supplies/equipment prevents the resident from developing respiratory infections caused by contaminated and old tubing/equipment used for longer periods of time. 3. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 1/26/2021, and readmitted the resident on 7/18/2025, with diagnoses including chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing), encephalopathy (any disease, damage, or malfunction of the brain that alters how it functions), and dysphagia (difficulty swallowing). During a review of Resident 5's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self understood and understand others and had severe cognitive impairment. The MDS indicated the resident was on oxygen therapy. During a review of Resident 5's OSR, dated 12/26/2025, the OSR indicated an order for: -Oxygen at 2 LPM via nasal cannula every shift for COPD. -Tubing and humidifier change every day shift every Saturday. During a concurrent observation and interview on 5/18/2026, at 9:45 a.m., with LVN 1, inside Resident 5's room, observed Resident 5's oxygen tubing was touching the floor and the clear plastic bag for the oxygen tubing was dated 5/11/2026. LVN 1 stated the oxygen tubing should not be touching the floor and the oxygen tubing should have been changed on Saturday (5/9/2026) to prevent respiratory infections to residents. During an interview and record review on 5/20/2026, at 11:34 a.m., with the MDSC, reviewed Resident (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5's MDS, OSR, and CP. The MDSC stated there was an order for the oxygen therapy on the resident, the oxygen via nasal cannula should be dated of when it was last changed to prevent respiratory infections to residents. The MDSC stated labeling the respiratory supplies ensures the facility was not using the supplies for more than a week. The MDSC stated the failure of the staff to label the respiratory supplies predisposed the residents to development of respiratory infections.ˆ During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated the oxygen via nasal cannula tubing of Resident 5 should have been discarded and replaced with the new oxygen via nasal cannula tubing with a label of the date it was last changed to know when to change them again. The DON stated that properly labeling the respiratory supplies/equipment prevents the resident from developing respiratory infections caused by contaminated and old tubing/equipment used for longer periods of time.ˆ 4. During a review of Resident 50's AR, the AR indicated the facility admitted the resident on 10/10/2025, with diagnoses including chronic myeloid leukemiaˆ(a slow-growing blood cancer that starts in the bone marrow), type 2 diabetes mellitusˆ(DM,ˆa disorder characterized by difficulty in blood sugar control and poor wound healing), and glaucomaˆ(a group of eye diseases that damageˆtheˆoptic nerve&mdash;the vital cable connectingˆtheˆeye toˆtheˆbrain).ˆ During a review of Resident 50's H&P, dated 10/10/2025, the H&P indicated the resident had the capacity to understand and make decisions.ˆ During a review of Resident 50's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment.ˆˆ During a concurrent observation and interview on 5/18/2026, atˆ9:53 a.m., with LVN 1, inside Resident 50's room, observed Resident 1 had a clear plastic bag containing a nebulizer mask and tubing labeled with the last name of the resident's roommate and had no date and was placed on top of Resident 50's drawer. LVN 1 stated the nebulizer mask and tubing in the clear plastic bag did not belong to Resident 20. LVN 1 stated all staff should make sure the respiratory supplies of residents should not be stored on another resident's drawer as it can cause cross-contaminationˆ(the unintentional transfer of harmful bacteria, viruses, or allergens from one surface, object, or food to another)ˆthat can cause the resident to get respiratory infections.ˆˆ During a concurrent interview and record review on 5/20/2026, at 11:46 a.m., with the MDSC, Resident 50's OSR and CP were reviewed. The MDSC stated there was no physician's order for Resident 50 for nebulization and had no care plan for nebulization therapy. The MDSC stated that the bag of nebulizer mask and tubing should not have been stored in Resident 50's drawer as it can cause cross-contamination and respiratory infection to residents.ˆˆ During an interview on 5/21/2026, at 1:52 p.m., with the DON, the DON stated Resident 50's drawer should be free of other resident's respiratory supplies to prevent Resident 50 from getting respiratory infections. The DON stated it was the responsibility of all staff in the facility to ensure resident's belongings and equipment remain on the resident's bed side and not mixed with other residents. The DON stated the failure of the staff to keep other resident's equipment in the resident's bedside had predisposed the residents to infection.ˆ 5. During a review of Residentˆ35's admission Record, the admission Record indicatedˆthe facility admitted the residentˆonˆ1/1/2026ˆwith diagnoses includingˆcongestive heart failure (CHF-a heart (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	humidifier every Saturday. The MDSC stated that Resident 35's NC tubing and humidifier should have been changed as ordered by the physician as it placed Resident 35 at risk for acquiring respiratory infection. During an interview on 5/21/2026 at 2:30 p.m. with the Director of Nursing (DON), the DON stated the oxygen tubing and humidifier are changed weekly per physician's order and facility practice and all clinical staff are responsible in making sure that the tubing and humidifier were labeled with the date it was last changed to ensure cleanliness and infection control. The DON stated that Resident 35's NC and humidifier should have been changed as scheduled on 5/16/2026 per physician's order and should be labeled with the date it was last changed and mark in the Respiratory TAR as it placed Resident 35 at risk for developing respiratory infection from the old tubing and humidifier. 6. During a review of Resident 59's admission Record (AR), the AR indicated the facility originally admitted the resident on 7/11/2025 and readmitted on [DATE], with diagnoses including pneumonia due to other specified infectious organisms (a specific germ that causes lung infection making the lungs swollen and fill with fluid or mucus, making it hard to breath); chronic obstructive pulmonary disease, unspecified (COPD- a chronic lung disease causing difficulty in breathing); and Acute respiratory failure, unspecified whether with hypoxia or hypercapnia (a serious condition where the lungs suddenly cannot provide enough oxygen or remove enough carbon dioxide from the body, causing trouble breathing). During a review of Resident 59's History and Physical (H&P), dated 4/21/2026, the H&P indicated that the resident was able to make decisions for activities of the daily living. During a review of Resident 59's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/2026, the MDS indicated the resident had the ability to usually make self-understood and usually understand others and had severe cognitive impairment (very limited memory, thinking, decision-making and need help with daily activities). The MDS indicated that Resident 59 needed dependent to partial/moderate assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and observation for Resident 59 on 5/18/2026, at 11:10 a.m., with Certified Nurse Assistant (CNA) 6 in Resident 59's room, observed the nasal cannula on the floor. CNA 6 stated that the nasal cannula should not be on the floor and nasal cannula needs to be changed. During an interview for Resident 59 on 5/20/2026, at 10:32 a.m., with Minimum Data Set Coordinator (MDSC) stated the nasal cannula should not be on the floor if not in use it should be in a labeled bag. The MDSC stated there is a potential risk for the resident to contract ascending respiratory infection (an infection that starts in the nose or throat and spreads down into the lungs). During an interview for Resident 59 on 5/21/2026, at 10:45 a.m., with Director of Nursing (DON) stated if the nasal cannula is on the floor it should be immediately discarded, staff should get a new one and label it so it can be changed on a weekly basis or when needed. The DON stated immediate action needs to be taken because if nasal cannula is continued to be used the resident can develop a respiratory infection. During a review of the facility's recent policy and procedure (P&P) titled, Policies and Procedures- (continued on next page)		

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection Prevention and Control, last reviewed on 4/23/2026, the P&P indicated the facility adopted infection prevention and control policies and procedures are intended to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections.^		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all drugs and biologicals to meet the needs of each resident for one (1) of three (3) sampled resident (Resident 48) by failing to ensure the licensed nurses (LNs) administered Resident 48's 9 a.m. dose of divalproex sodium (a type of medication to treat epilepsy (a brain condition that causes a person to have repeated, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness]), manage the manic or mixed episodes of bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and prevent migraine headaches and levetiracetam (also known as Keppra, a prescription medication used to prevent and control seizures in people with epilepsy) on 5/13/2026 and 5/17/2026. This deficient practice placed Resident 48 at risk for complications and delay in the necessary care and services needed related to not receiving the medications as prescribed by the physician such as uncontrolled seizures and increase in mood swings from being calm to striking out which may lead to hospitalization. Findings: During a review of Resident 48's admission Record, the admission Record indicated the facility originally admitted the resident on 4/9/2020, and readmitted in the facility on 6/23/2024, with diagnoses including epilepsy, schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 48's History and Physical (H&P) dated 3/14/2026, the H&P did not indicate Resident 22's capacity to understand and make decisions but indicated that the resident had cognitive impairment. During a review of Resident 48's Minimum Data Set (MDS, a resident assessment tool), dated 5/14/2026, the MDS indicated Resident 48 had moderately impaired cognition (having the ability to think, learn, and remember clearly) but able to understand and make his need known. The MDS indicated Resident 48 was independent with eating, bed mobility, and shower transfers; total assistance with toileting hygiene and lower body dressing; supervision/touching assistance with bathing, upper body dressing, and personal hygiene; setup or clean-up assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 48 received an anticoagulant (a blood-thinning medication used to prevent and treat blood clots in blood vessels and the heart to reduce the risk of having a stroke) medication. During a review of Resident 48's Order Summary Report dated 5/20/2026, the Order Summary Report indicated the following physician's orders: - 3/14/2026: divalproex sodium oral tablet delayed release 250 milligrams (mg - a unit of measurement) give 1 tablet by mouth two (2) times a day for schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) bipolar type (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). - 3/14/2026: levetiracetam tablet 500 mg by mouth two times a day for seizure. During a review of Resident 48's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2026, the MAR indicated Resident 48's divalproex sodium and levetiracetam on 5/13/2026 and 5/17/2026 were marked with a check and the licensed nurses' initials. During a review of Resident 48's care plan (CP) on schizoaffective disorder bipolar type and risk for injury related to seizure activity initiated on 5/20/2026, the CP indicated to administer the medications as ordered, to monitor/document for side effects and effectiveness, and monitor seizure frequency, duration and triggers to keep Resident 48 free from injury and demonstrated reduced seizure frequency and fewer episodes of mood swings. During an observation of medication administration on 5/18/2026 at 8:08 a.m. and concurrent interview and record review, reviewed Resident 48's blister packs (a card that packages doses of (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication within small, clear, or light-resistant, amber-colored plastic bubbles [or blisters]) and Medication Administration Record (MAR) with Licensed Vocational Nurse (LVN) 2. LVN 2 stated Resident 48's 9 a.m. dose of divalproex sodium and levetiracetam for 5/13/2026 and 5/19/2026 remained in the blister pack and were marked as administered in the MAR as indicated by a check mark and initials of the LNs who administered the medications. LVN 2 stated Resident 48's blister pack for divalproex sodium and levetiracetam indicated the medications were cycle medications. LVN 2 stated that the new medication cycle for all their long-term residents starts on the first day of each month and nurses are supposed to start removing medications from the number 1 slot. LVN 2 stated that if Resident 48's medications remained in the blister pack, it could mean that the medications were not given and placed Resident 48 at risk for complications such as uncontrolled seizures and increase in mood swings. LVN 2 stated that during medication administration, the LNs are supposed to administer the medication first prior to signing the MAR. During a concurrent interview and record review on 5/21/2026 at 9:25 a.m., with the MDS Coordinator (MDSC), a photographs of Resident 48's blister pack for divalproex sodium and levetiracetam, physician's orders, and MAR were reviewed. the MDSC stated that Resident 48 had a physician's order for divalproex sodium and levetiracetam, the photographs of the blisters indicated that the 9 am doses of divalproex sodium and levetiracetam for 5/13/2026 and 5/17/2026 remained in the blister packs, and that the MAR for 5/2026 indicated a check mark and initials of the LNs. The MDSC stated that the check mark and initials of the LNs indicated that the medications were administered. The MDSC stated that the cycle medications for all their long-term residents start on the first day of each month and nurses are supposed to start removing medications from the number 1 slot. The MDSC stated if Resident 48's medications remained in the blister pack, the medications were not administered, it can affect the effectiveness of the medications, and placed Resident 48 for episodes of seizure and increase in mood swings which can lead to hospitalization. The MDSC stated the LNs are supposed to sign the MAR after the medications were administered. During an interview on 5/21/2026 at 11:29 a.m. with the Director of Nursing (DON), the DON stated the medications are supposed to be given by the LNs assigned to the residents as ordered by the physician and the MAR needs to be signed after the medication was administered and not to miss any days of the medications to prevent the health conditions to worsen. The DON stated that if the medication was not administered, there should be a note in the MAR for the reason the medications were not administered. The DON stated that cycle meds start on the first day of each month and the medications should be removed from the blister pack according to the day of the month. The DON stated that Resident 48's 9 a.m. dose of the divalproex sodium and levetiracetam that remained in the blister pack for 5/13/2026 and 5/17/2026 should have been administered as ordered by the physician as it placed Resident 48 at risk for increase in mood swings and seizure activity and hospitalization. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, last reviewed on 4/23/2026, the P&P indicated: - Medications are administered in a safe and timely manner, and as prescribed. - Medications are administered in accordance with prescriber orders, including any required time frame. - Medications are administered within 1 hour of their respected prescribed time, unless otherwise specified. - If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose. - The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next one. - As required or indicated for a medication, the individual administering the medication records in the resident's medical record the date and time the medication was administered, the dosage, the route of administration, and the signature and title of the person administering the drug.		

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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. Based on interview and record review, the facility failed to ensure one of one sampled resident (Resident 5) was free of any significant medication errors (means 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) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use. The facility failed to rotate (a method to ensure repeated injections are not administered in the same area) Resident 5's subcutaneous (sq, beneath the skin) insulin administration sites. This deficient practice had the potential for Resident 5 to experience adverse effect (unwanted, unintended result) of same-site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 1/26/2021, and readmitted the resident on 7/18/2025, with diagnoses including type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), encephalopathy (any disease, damage, or malfunction of the brain that alters how it functions), and dysphagia (difficulty swallowing). During a review of Resident 5's Minimum Data Set (MDS, a resident assessment tool), dated 3/11/2026, the MDS indicated the resident rarely to never had the ability to make self understood, understand others, and had severe cognitive impairment (a person has lost their mental ability to the point they can no longer live independently or safely care for themselves). The MDS indicated Resident 5 was on a high-risk drug class hypoglycemic medication (prescription drugs used to lower high blood sugar (glucose) levels). During a review of Resident 5's Order Summary Report (OSR), the OSR indicated an order for the following: a. 2/12/2026 Novolin R Injection Solution 100 units per milliliters (unit/ml, tells how concentrated the medication is-specifically, how much active insulin is packed into every 1 milliliter (mL) of liquid) (Insulin Regular (Human)). Inject as per sliding scale (a personalized chart that tells how much fast-acting insulin to take based on the blood sugar level right before a meal): if 70 - 150 = 0 units; 151 - 200 = 4 units; 201 - 250 = 7 units; 251 - 300 = 10 units; 301 - 350 = 13 units; 351 - 400 = 16 units blood sugar (BS) greater than (>) 400 administer 18 units and immediately call MD, subcutaneously four times a day for DM 2. Rotate site. b. 2/14/2026 Lantus Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 30 unit subcutaneously at bedtime for DM II hold if BS less than (<) 100 milligrams per deciliter (mg/dl, the standard unit of measurement used in the U.S. to describe the concentration of sugar in your blood). Rotate and record administration site. During a review of Resident 5's Location of Administration Report (LAR) on the use of Insulin for 4/2026, the LAR indicated: Lantus Subcutaneous Solution 100 unit/ml was administered subcutaneously on the following: 4/6/2026 at 9:23 p.m. on the Arm - left 4/7/2026 at 9:23 p.m. on the Arm - left 4/13/2026 at 9 p.m. on the Arm - right 4/14/2026 at 9:22 p.m. on the Arm - right 4/19/2026 at 9:16 p.m. on the Arm - right 4/20/2026 at 10:02 p.m. on the Arm - right 4/27/2026 at 8:56 p.m. on the Arm - right 4/28/2026 at 8:21p.m. on the Arm - right Novolin R Injection Solution 100 unit/ml was administered subcutaneously on: 4/7/2026 at 9:28 p.m. on the Arm - left 4/8/2026 at 9 a.m. on the Arm - left 4/11/2026 at 9:05 p.m. on the Abdomen - Right Upper Quadrant (RUQ) 4/12/2026 at 8:21 a.m. on the Abdomen - RUQ 4/18/2026 at 8:33 a.m. on the Abdomen - RUQ 4/18/2026 at 8:09 p.m. on the Abdomen - RUQ 4/19/2026 at 12:38 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 4/20/2026 at 9:43 a.m. on the Abdomen - LLQ 4/21/2026 at 11:53 a.m. on the Abdomen - RUQ 4/21/2026 9:30 p.m. on the Abdomen - RUQ 4/23/2026 at 4:53 p.m. on the Abdomen - RUQ 4/23/2026 at 9:30 p.m. on the Abdomen - RUQ During a review of Resident 5's Care Plan (CP) Report titled, Resident is hyperglycemic (having too much sugar (glucose) in the blood) related to diagnosis of diabetes mellitus., last revised on 11/3/2025, the CP indicated an intervention to administer medication as ordered. During a concurrent interview and record review on 5/20/2026, at (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:23 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 5's OSR, LAR, and CP were reviewed. The MDSC stated there were orders for insulins and there were multiple instances on the LAR for 4/2026 where insulin administrations were not rotated. The MDSC also stated that the CP titled, Resident is hyperglycemic related to diagnosis of diabetes mellitus., was not followed. The MDSC stated it was important to ensure insulin sites of administration were rotated to prevent lipodystrophy on residents. The MDSC stated there was an order to rotate insulin administration sites, but it was not followed. The MDSC stated not following MD orders to rotate insulin administration sites was a medication error. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated Resident 5's insulin administration sites should have been rotated to prevent lipodystrophy and cutaneous amyloidosis on residents. The DON stated injecting insulin on sites of lipodystrophy could result in hypo (low)/hyperglycemia to residents. The DON stated not rotating insulin administration sites was considered a medication error. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 4/23/2026, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. General Guidelines 16. Select an injection site. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed on 4/23/2026, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Adverse Consequences 1. An adverse consequence refers to an unwanted, uncomfortable or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. Side effect; c. Medication-medication interaction; or d. Medication-food interaction. Medication Errors A medication error is defined as the preparation or administration of drugs or biologicals which is not in accordance with physician's orders, manufacturer's specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility-provided Highlights of Prescribing information (HPI) on the use of Lantus (insulin glargine) injection, for subcutaneous use, with initial U.S. approval in 2000, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided HPI on the use of Novolin R (insulin human) injection, for subcutaneous or intravenous use, with initial U.S. approval in 1991, the HPI indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the abdominal area, buttocks, thigh or the upper arm. Rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on interview and record review, the facility failed to ensure one out of two sampled dietary aids (DA) specific competency and skills checklist for year 2024 and 2025 were completed. This deficient practice has the potential to negatively affect residents such as improper food handling and unsafe practices to prevent foodborne illness or cross contamination in the kitchen. Findings: During a concurrent interview and record review on 5/21/2026 at 10 a.m. with the Director of Staff Development (DSD), DA 1's employee file was reviewed. The DSD stated there was no documentation to indicate a current skills check list for the year 2024 and 2025. The DSD stated the last skills check in the employee file was completed 2023. The DSD stated the last in-service skills check list was not found in the file as well. During an interview on 5/21/2026 at 10:10 a.m. with the DSD, the DSD stated that performance evaluations are important for competency and quality of care. The DSD stated it is her (DSD) responsibility to make sure performance evaluations are being done timely. The DSD explained that when the skills check list is not completed, it means that the employee was not evaluated to make sure still can perform job properly. The DSD stated it is important to keep performance evaluations locked in a cabinet to protect employee privacy. During a review of the Dietary Aide Job Description, dated 03/2021, the job description indicated that dietary aides comply with all company and departmental policies and procedures; and attends orientation, in services and meetings as required. Participates in OSHA and CDC in-service training programs for hazardous communication, TB management, and blood borne pathogens standard. May participate in workshops and seminars to stay current with changes in field, as well as to maintain professional status. During a review of the Facility Assessment, dated 3/1/2026 to 3/1/2027, the facility assessment indicated action to be taken/already taken this year for training, competencies the staff competency training review showed; no need to match training needs with resident needs. Review the training of all staff based on condition; equipment use; therapy schedule/assistance; special skills; rights of the individual and the representation to be involved in person centered care; Baseline care plan; comprehensive care plan; resident right to copies of their record/care plan; therapy schedules and transport training identified for focus.		

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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 ensure the Head [NAME] (HC) used the correct scoopers during tray line service for residents on small- portion diets including residents who are on level four (4) International Dysphagia Diet Standardization Initiative diet (a diet texture for individuals with severe swallowing difficulties) diet. This deficient practice has potential for residents who require small portions and are at risk for receiving inaccurate serving sizes, which has the potential to cause unintended weight gain or loss. Findings: During an observation of the tray line on 5/18/2026 at 11:57 a.m. with the HC, the HC was observed serving mashed potatoes. The HC scooped the potatoes using a size 8 scooper (holds 4 fluids ounces [a unit of measure for volume]) as each tray moved down the line. The potatoes were portioned directly from the pan at the steam table. The HC continued serving in the same manner for all residents assigned to receive the small portion. During a review of the facility's [NAME] Spreadsheet Spring Menu for week 4, dated 5/18/2026, the spreadsheet indicated for the mashed potatoes prepared for the Level 4 pureed (extremely thick) diet, staff are required to use two scoopers, a size eight (8) and a size 12 (holds between 2.7 to 3.2 fluid ounces) to ensure correct portioning. During a concurrent interview and record review on 5/18/2026 at 1:18 p.m. with the HC, facility's [NAME] Spreadsheet Spring Menu for week 4, dated 5/18/2026, was reviewed. The HC stated that the spreadsheet has the measurements or scooper to use during tray line. The HC stated that the spreadsheet has two scoopers, one for small portions size #12 and one for regular portions #8. The HC stated the #12 scooper is for vegetables and the size #8 and #12 should be in the mashed potato for regular portions and small portions diet. The HC stated that she was missing the green scooper size # 12 and it is important to serve the correct portion for Resident's weight management. During an interview on 5/19/2026 at 9:51 a.m. with the Dietary Supervisor (DS), the DS stated staff should use the correct scooper based on spreadsheets. The DS stated that the correct procedures are posted for the cook to follow. The DS emphasized that using the appropriate scooper is important to ensure accurate portion sizes for each resident, which directly affects their prescribed diet, caloric intake, and nutritional count. During an interview on 5/19/2026 at 1:41 p.m. with the Registered Dietitian (RD), the RD stated measuring out portions is important because if the resident needs less calories the measurement of food has to be accurate so that residents do not gain weight. During a review of the Head [NAME] Job Description, undated, the job description indicated duties and responsibilities include review menus prior to preparation of food; prepare meals in accordance with planned menus, serve food in accordance with established portion control procedures, inspect special diet trays to assure that the correct diet is being served. During a review of the Dietary Supervisor Job Description, dated 3/21/2021, the job description indicated duties and responsibilities include assisting in ensuring that menus are developed, filled and served in accordance with established policies and procedures and in compliance with physician orders and assists in developing methods for determining quality and quantity of food served.		

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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 safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1. Ensure pasteurized eggs (raw eggs that have not been heat-treated to kill harmful bacteria) were available for use. 2. Ensure cleaning logs were dated and kept up to date, including the cleaning logs for the ice machine. 3. Identify and address condensation observed in the freezer. 4. Ensure clean scoops were available for rice and oatmeal. 5. Ensure the measuring scoop for the thickener was properly stored instead of being placed on top of the container after use. These failures had the potential to promote foodborne illness and cross-contamination (unintentional transfer of harmful germs, allergens, or chemicals from one surface, food, or person to another) by exposing residents to unsafe food handling, improper storage conditions, and inadequate hygiene practices in the kitchen. Findings: 1. During a review of Resident 37's admission Record, the admission record indicated the facility initially admitted Resident 15 on 1/29/2026, with a diagnoses including osteomyelitis (a serious infection and inflammation of the bone or bone marrow) of the lower leg; cellulitis (bacterial infection of the skin and underlying tissues) of right lower limb, and cellulitis of left lower limb During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool), dated 4/29/2026, the MDS indicated Resident 37's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact with no impairment. The MDS indicated Resident 37 does not have a swallowing disorder and is on a therapeutic diet. During an initial kitchen tour observation on 5/18/2026 at 7:37 a.m. at the walk-in refrigerator, there were unpasteurized eggs labeled grade AA found on the lowest shelf with an open date of 5/17/2026. During an interview on 5/18/2026 at 8:20a.m. with the Head [NAME] (HC), the HC stated there are medium eggs stored in the walk-in refrigerator. The HC stated there are two residents that ate sunny side up unpasteurized eggs today, including Resident 37. During an interview on 5/18/2026 at 11:13 a.m. with Dietary Aide (DA) 1 and the HC, the HC stated unpasteurized eggs found in the lowest shelf had no letter P on any eggs. The HC and DA 1 stated those eggs were used this morning to serve the sunny side egg. During an interview on 5/18/2026 at 11:13 a.m. with the Dietary Supervisor (DS), the DS stated when he (DS) ordered eggs, he (DS) thought he ordered pasteurized eggs. The DS stated Dietary Aides are responsible to check if the eggs are not pasteurized. The DS stated the he (DS), the HC, or dietary aides would check the deliveries in the facility to ensure compliance. The DS stated that pasteurized eggs are needed for safety since the elderly have compromised immune systems and are at risk for salmonella (group of bacteria that causes infection of the intestinal tract). During an interview on 5/18/26 at 12:42 p.m. with Resident 37, Resident 37 stated he (Resident 37) ate eggs this morning. During a concurrent interview and record review with the DS on 5/19/26 at 9:51 a.m., the DS stated the suppliers were out of eggs this one time. The DS stated when he (DS) orders unpasteurized eggs, the facility has to cook the eggs to 165 degrees Fahrenheit (scale used to measure temperature) to kill salmonella. During a review of the invoice from the supplier, dated 5/13/2026, the invoice showed an order for two quantities for eggs large loose 15 dozen. The invoice did not indicate that the eggs were pasteurized. During an interview on 5/19/2026 at 1:41 p.m. with the Registered Dietician (RD), the RD stated she (RD) inspects the kitchen monthly and conducts in-services as needed. The RD stated eggs that are not pasteurized could contain harmful bacteria. The RD stated not providing pasteurized egg to residents can cause Salmonella. During a review of the Food Code Manual, dated 2022, the food code manual indicated egg products shall be obtained pasteurized. 2. During an observation on 5/18/2026 at 7:40 a.m. of the ice machine, the ice machine's log indicated the dates 4/21/2026 and 5/3/2026, 12 days apart. During an interview on 5/18/2026 at 7:55 a.m. with DA 1, DA 1 stated HC and her (DA 1) are responsible to make sure check the logs are completed at the beginning of their shift. During a kitchen observation on 5/18/2026 at 11:11 a.m., the daily cleaning (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	schedule of the dietary department log paper posted at the bulletin board was not labeled with a month and year. During a concurrent interview and record review on 5/18/2026 at 11:13 a.m. with the DS, the daily cleaning schedule dietary log was reviewed. The DS stated that the daily cleaning schedule dietary log needs to be done daily. The DS stated the log does not have a date and year. The DS stated that he (DS) expected that it should be done daily as this will assure the areas are being cleaned daily to prevent food borne illnesses. The DS stated if there is no date or year, the staff will not be aware when the cleaning was done. During an interview on 5/19/2026 at 9:51 a.m. with the DS, the DS stated he expected the logs in the kitchen to have complete documentation. The DS stated dietary aides are responsible for making sure it is done daily. During an interview on 5/19/2026 at 1:41 p.m. with the RD, the RD stated that the logs in the kitchen needs to be done daily, weekly or monthly as scheduled to maintain sanitation. 3. During an observation on 5/18/2026 at 8:10 a.m. with the vegetable freezer, the freezer had condensation. During an interview on 5/19/2026 at 9:51 a.m. with the DS, the DS stated that it is the responsibility of Maintenance Supervisor (MS) to make sure there is no condensation because if there are ice crystals the freezer, it prevents circulation for cooling. The DS stated that the main goal in the kitchen is to be clean and maintain good sanitation. During a review of the Food Code manual, dated 2022, the manual indicated equipment compartments are subject to accumulation of moisture due to conditions such as condensation, food or beverage drip, or water from melting ice shall be sloped to an outlet that allows complete drainage. 4. During an initial tour to the kitchen on 5/18/2026 at 11:55 a.m. at the food preparation table, the scooper for thickened liquid sat on top of a container. The scooper had white residue. During an interview on 5/18/2026 at 11:55 a.m., DA1 stated that staff should place the scooper in a small cup to keep it clean. DA 1 stated staff should not leave the scooper on top of the container lid. During a concurrent observation and interview on 5/18/2026 at 1:37 p.m., the HC stated that staff wash the scoop used for dry storage and place it back in the dry storage room inside its holder. The HC stated the container holding the scooper has no date and that residue is visible on the scooper and at the bottom of the scoop container. During an interview on 5/19/2026 at 9:51 a.m. with the DS, the DS stated that staff should place the scooper in a separate container and clean it after each use. The DS added that staff should not place the scooper on top of the thickener container. The DS stated that the scooper in the dry storage room has no date indicating when it was last cleaned. The DS explained that staff use a scoop or measuring cup based on what the recipe requires, and emphasized that using the correct measuring cup is important to follow the recipe. The DS stated that staff use different scoopers to prevent cross-contamination. The DS stated staff may use the same scooper, but they must disinfect or clean it between uses. The DS stated that the metal pitcher used to measure rice has measuring lines, making it easier for staff. The DS stated that staff should clean the thickener scooper after each use and return it to its designated area. The DS stated the designated area should be a bag or container to prevent contamination. The DS stated that they were surprised the scooper was not dated. During a review of the facility's policy and procedure (P&P) titled, Sanitation, dated 1/2026, the P&P indicated the food service area is maintained in a clean and sanitary manner. The P&P indicated all equipment food contact surfaces and utensils are cleaned and sanitized using heat and chemical sanitizing solution. During a review of the facility's P&P titled, Refrigerators and Freezers, the P&P indicated the facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation, and will observe food expiration guidelines. Supervisors inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. Maintenance schedules per manufacturer guidelines are scheduled and followed.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain medical records on each resident that are complete, accurately documented, readily accessible, and systematically organized to one (1) of 1 sampled resident (Resident 46) reviewed for pain management by failing to document timely and per facility policy the administration of pain medications oxycodone (a powerful, prescription-only opioid pain reliever [narcotic]) and ibuprofen (an over-the-counter and prescription medication used to reduce pain, fever, and inflammation). These deficient practices had a potential in the delay of medication administration and places Resident 46 at risk for undue pain. Findings: During a review of Resident 46's admission Record (AR), the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including mood disorder (a mental health condition that primarily affects your emotional state), generalized anxiety disorder (GAD - is characterized by excessive anxiety and worry about a variety of events or activities), and alcohol dependence (a chronic brain disease characterized by a compulsive need to drink). During a review of Resident 46's History and Physical (H&P), dated 4/11/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 4/15/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in memory, learning, or thinking skills that goes beyond the normal aging process). The MDS indicated that the resident received if needed (PRN) pain medications or was offered and declined. The MDS indicated the resident was on a high-risk drug class opioid medication (powerful medications primarily prescribed to treat moderate to severe pain). During a review of Resident 46's Order Summary Report (OSR), the OSR indicated an order for: 4/10/2026 Ibuprofen Oral Tablet 400 milligrams (mg - a unit of weight). Give one tablet by mouth with meals for Pain level 1-3 and give 1 tablet by mouth at bedtime for Pain 1-3. 5/9/2026 Oxycodone HCl Oral Tablet five (5) mg. Give 1 tablet by mouth every four (4) hours as needed for Moderate pain (5-7). 5/9/2026 Oxycodone HCl Oral Tablet 10 mg. Give 1 tablet by mouth every 4 hours as needed for Severe pain 8-10. During an interview on 5/18/2026 at 10:18 a.m. with Resident 46, Resident 46 stated her (Resident 46) pain medications were given late most of the time. Resident 46 cannot remember the details of the events, the date they happened, what time, and who was the licensed nurses who gave her pain medications late. During a review of Resident 46's Medication Admin Audit Report (MAAR) for 5/2026, the MAAR indicated: -Oxycodone HCl Oral Tablet 5 mg. Give 1 tablet by mouth every 4 hours as needed for severe pain 8-10 for 14 days was given on: Scheduled TimeAdmin TimeDocumented Time 5/3/2026 3 a.m.3 a.m.4:40 a.m. 5/4/2026 2:45 a.m.2:45 a.m.3:35 a.m. - Oxycodone HCl Oral Tablet 10 mg. Give 1 tablet by mouth every 4 hours as needed for Severe pain 8-10 was given on: Scheduled TimeAdmin Time Documented Time 5/11/2026 5:45 p.m.5:45 p.m.6:45 p.m. 5/12/2026 4:30 a.m.4:30 a.m.5:55 a.m. 5/15/2026 8:05 p.m.8:05 p.m.9:06 p.m. 5/21/2026 1 a.m.1 a.m.2 a.m. - Ibuprofen Oral Tablet 400 mg. Give 1 tablet by mouth with meals for Pain level 1-3 AND Give 1 tablet by mouth at bedtime for Pain 1-3 was given on: Scheduled TimeAdmin TimeDocumented Time 5/4/2026 12:30 p.m.1:07 p.m.1:41 p.m. 5/17/2026 7:30 a.m.7:10 a.m.8:50 a.m. -Ibuprofen Oral Tablet 400 mg. Give 1 tablet by mouth with meals for pain level 1-3 was given on: Scheduled TimeAdmin TimeDocumented Time 5/1/2026 7:30 a.m.8:57 a.m.8:58 a.m. 5/5/2026 7:30 a.m.10:22 a.m.10:22 a.m. 5/5/2026 12:30 p.m.1:38 p.m.1:39 p.m. 5/6/2026 12:30 p.m.1:53 p.m.1:53 p.m. 5/6/2026 5:30 p.m.5:04 p.m.7:04 p.m. 5/7/2026 7:30 a.m.9:47 a.m.9:48 a.m. 5/7/2026 12:30 p.m.3:09 p.m.3:09 p.m. 5/9/2026 7:30 a.m. 10:33 a.m.10:34 a.m. During an interview on 5/21/2026 at 11:54 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated when she (LVN 2) administers pain medication, especially if it was a narcotic, she (LVN 2) documents the administration as soon as she (LVN 2) gives the medication. LVN 2 reviewed Resident 46's MAAR and stated the documented time (3rd column of the report) was the reassessment of pain after (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administration but cannot provide evidence about the claim since there were no time stamps on the pain medication reassessment shown on the MAR. During a concurrent interview and record review on 5/21/2026 at 11:55 a.m. with the Medical Records Director (MRD), Resident 46's MAAR was reviewed. The MRD stated the first column of the report was the scheduled time, the second column was the administration time, the third column was documented time, and the fourth column was who the medication was given by. The MRD stated the licensed nurses makes rounds (visits to other residents) first before they document the administration of pain medication which could possibly explain the variance in the timing on the third column. During a concurrent interview and record review on 5/21/2026 at 11:57 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 46's MAAR was reviewed and the MDSC stated the MAAR had four columns, the first one was the scheduled time, the second was the admin time, the third was documented time, and the last was administered by. The MDSC stated the documented time was for the reassessment of pain. During a concurrent interview and record review on 5/21/2026 at 11:58 a.m. with the Director of Nursing (DON), Resident 46's MAAR was reviewed and the DON stated pain medications when administered should be documented as soon as given, a 30-minute allowance is afforded to the staff when documenting. The DON stated there were several instances where the pain medication was documented given for more than 30 minutes. The DON stated it was important to document the pain medication administration as soon as given to prevent skewing of medication administration times that can cause confusion to residents and the licensed staff. During a review of the facility's recent policy and procedure (P&P) titled, Charting and Documentation, last reviewed on 4/23/2026, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. the medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. ^During a review of the facility's recent P&P titled, Administering Medications, last reviewed on 4/23/2026, the P&P indicated medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. During a review of the facility's recent P&P titled, Pain Assessment and Management, last reviewed on 4/23/2026, the P&P indicated the purposes of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain. General Guidelines 5. Acute pain (or significant worsening of chronic pain) should be assessed every 30 to 60 minutes after onset and reassessed as indicated until relief is obtained.		

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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. Based on interview and record review, the facility failed to ensure staff followed the facility's Infection Prevention Control Policy to prevent the spread of infection, when facility failed to ensure the facility's Water Management Program (WMP - a written, step-by-step plan for buildings to ensure their water system was safe, clean, and efficient) was implemented as written. This failure had the potential to result in a lack of a structured plan and allows dangerous pathogens to thrive in the water system, that can lead to disease outbreaks in the facility and cause residents to get sick. Findings: During a concurrent interview and record review on 5/20/2026 at 11:20 a.m. with the Infection Preventionist (IP) and Maintenance Supervisor (MS), the facility's document titled, Water Management Program 2026 Committee was reviewed. The IP stated that he (IP) and the MS are responsible for the water management plan for the facility. The Water Management Program 2026 Committee indicated the meeting was conducted on 1/2/2026. The IP stated the purpose of water management is to prevent having legionella (bacteria found in freshwater environments can multiply rapidly in man-made water systems, posing a serious health risk if inhaled as mist or vapor) in the facility. The IP stated that he (IP) is not responsible for the implementation of water management since he (IP) was not the one checking the temperatures. The IP stated the MS checked the water temperatures. The MS stated that he (MS) checks the hot temperature but not the cold temperature or the chlorine content for any of the water sources. The IP stated the legionella infection prevention plan meeting includes the Administrator (ADM), me (IP), and the MS. The IP stated the MS is supposed to oversee Legionella. The MS stated he (MS) only checks hot temperature, does not perform chlorine testing, and does not check cold water temperatures. The IP stated the ADM is aware of the water management plan. The IP and MS stated the plan provided doesn't talk about what to do in an emergency, if needed. During a review of the facility's policy and procedure (P&P) titled, Legionnaire's Disease, dated 6/2017, the P & P indicated the facility will determine risk areas by completing the Building Water System Process Flowchart, implement controls, and indicate where these controls are located by completing the Control Area Monitoring Flowchart. During routine inspections of control areas, the facility will attempt to reduce areas of concern with the specific plans that have been developed. Preventative maintenance plans have been developed for each control area. During a review of the facility's Environmental Assessment Form (EAF), undated, the EAF indicated the section for who is completing the assessment was blank or not completed. The EAF indicated the total rooms and number of buildings was not filled out. The EAF indicate the section where the buildings with supplemental disinfection was blank or not filled up. The EAF for Measured Water System Parameters indicated to measure and document the current physical and chemical characteristics of the potable water, as this can help determine whether conditions are likely to support Legionella growth-think sediment, temperature, water age, and disinfectant residual. STEP 1: Plan a sampling strategy that incorporates all central water heaters/boilers, storage tanks, and various points along each loop of the potable water system. For example. If the facility has one loop serving all occupant rooms, an occupant room near (proximal) the central hot water heater and another at the farthest point (distal) of the loop should be sampled, at a minimum. STEP 2: For each sampling point (e.g., tap in an occupant room), turn on the hot water tap and allow the hot water tap to run until is it as hot as it will get. Collect at least 50 milliliter (ml - a unit of measure for volume) and measure the temperature. Document the temperature and the time it took to reach the maximum temperature. Measure the disinfectant level and pH (measurement that indicates how acidic or basic a liquid is). Measure free chlorine if the disinfectant is chlorine. Measure total chlorine if another disinfectant is used. Repeat for the cold water after letting the tap run for 30 seconds.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: 1. Ensure the influenza (also known as the flu, a highly contagious viral infection that attacks the respiratory system) Vaccination Record consent was signed by the Licensed Vocational Nurse (LVN) and the witness signature was obtained for four of four sampled residents (Resident 15,51,50 and 28). 2. Ensure one of four sampled residents (Resident 28) had documented evidence that the pneumonia (an infection in one or both lungs that causes lungs to become inflamed and fill with fluid or pus) vaccine was offered and administered when the consent was signed 9/2025 for Resident 28. These failures had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to pneumonia and influenza. Findings: 1a. During review of Resident 15's admission Record, the admission record indicated Resident 15 was initially admitted to the facility on [DATE], with diagnoses including type II diabetes (DM - a chronic condition that affects the way the body processes blood sugar) with foot ulcer (an open sore, wound, or crater that develops on the skin of your foot), immunodeficiency (weakened or absent immune system, making the body highly susceptible to frequent, severe, or unusual infections), and atherosclerotic heart disease (a condition where fatty deposits build up and harden inside your arteries, restricting oxygen-rich blood flow to your organs and limbs). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 15's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were moderately impaired. The MDS indicated Resident 15 required maximal assistance from staffs for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 15's Flu Vaccination Record Consent, dated 2/24/2026, the Flu Vaccination Record Consent indicated a missing signature from the licensed nurse who obtained and verified the consent. 1b. During review of Resident 51's admission Record, the admission record indicated Resident 51 was initially admitted to facility on 1/23/2026 with a diagnoses including DM with foot ulcer, cellulitis (potentially serious bacterial skin infection) of the left lower limb, and paraplegia (a medical condition characterized by partial or complete paralysis of the lower half of the body). During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 15's cognitive skills for daily decisions were intact with normal thinking and memory function. The MDS indicated Resident 51 requires partial moderate assistance from staff for ADLs. During a review of Resident 51's Flu Vaccination Record Sheet, dated 1/28/2026, the Flu Vaccination Record Consent indicated a missing signature from the licensed nurse who obtained and verified the consent. 1c. During review of Resident 50's admission Record, the admission Record indicated Resident 50 was initially admitted to facility on 10/10/2025, with diagnoses including leukemia (a group of cancers that affect the blood and bone marrow) and DM . During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 50 required moderate assistance from staffs for ADLs. During a review of Resident 50's Flu Vaccination Record Sheet, dated 10/23/2025, the Flu Vaccination Record Sheet did not indicate a licensed nurse signature who obtained and witnessed for the signature. 1d. During review of Resident 28's admission Record, the admission record indicated Resident 28 was initially admitted to facility on 8/29/2025 with diagnoses including displaced fracture of fourth cervical vertebra (the fourth bone from the top of your neck is broken and has moved out of its normal alignment) and fracture of nasal bones (a crack or break in one or both of the paired nasal bones). During a review of Resident 28's MDS, dated [DATE], the MDS indicated Resident 28's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 28 required maximal assistance from staffs for ADLs. During an interview on 5/20/2026 at 8:42 a.m. with the Infection Preventionist (IP), the IP stated residents that are newly admitted will be offered the influenza and pneumonia vaccine within the first five days of admission. During concurrent (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review and interview on 5/20/2026 at 8:42 a.m. with the IP, Resident 15's Informed Consent for Pneumococcal Polysaccharide Vaccine and Immunization Record, dated 2/24/2026, was reviewed. Resident 15's Informed Consent for Pneumococcal Polysaccharide Vaccine indicated the vaccine was administered six days after the consent was signed. The IP stated vaccines should be administered as soon as possible after the consent was signed by the resident to make sure any signs and symptoms that will show up after the vaccine is administered will be related to the vaccine. The IP reviewed Resident 15, 51, and 50's Flu Vaccination Record Consent and stated Resident 15, 51, and 50's consents were missing the licensed nurse's signature for who obtained the consent. The IP stated it is important for forms to be completed and signed by whoever obtained the consent to make sure that the vaccines were explained. 2. During a concurrent interview and record review on 5/20/2026 at 10:28 a.m. with the IP, the IP stated Resident 28 refused the flu vaccine in 9/2025. The IP stated he (IP) does not recall if the pneumococcal vaccine was offered since it is not in Resident 28's medical record. The IP stated consents and vaccine records are missing for Resident 28. The IP stated it is important for forms to be completed, signed, and filed in the medical records. During a review of the facility's policy and procedure (P&P) titled, Influenza Vaccine, dated 1/2026, the P&P indicated all residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. During a review of the facility's P&P titled, Pneumococcal Vaccine, dated 1/2026, the P&P indicated all residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has already been vaccinated. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: 1. Provide documented evidence of all employees screening, education, offering, and current Corona virus disease, COVID-19 (highly contagious respiratory illness caused by the SARS-CoV-2 virus) vaccination (medications used to prevent diseases usually given by injection) status. 2. Ensure COVID-19 vaccine screening was done for two of three sampled residents (Resident 50 and 51). These failures had the potential to place staff and residents at risk for serious outcomes such as being hospitalized due to COVID-19. Findings: 1. During a concurrent interview and record review on 5/20/26 at 8:42 a.m. with the Infection Preventionist (IP), the Staff roster vaccination list was reviewed. The Staff roster vaccination list indicated the sections for the Administrator, Dietary Aide 1, and Head [NAME] were blank. The IP stated he (IP) does not have the Administrator, Dietary Aide 1, and the Head Cook's records. During a review of the facility's policy and procedure (P&P) titled, Corona virus Disease (COVID-19)-Vaccination of Staff, dated October 2022, the P&P indicated staff are required to be fully vaccinated for COVID-19 unless exempted by law. 2a. During review of Resident 51's admission Record, the admission record indicated Resident 51 was initially admitted to facility on 1/23/2026, with diagnoses including type two diabetes (DM - a chronic condition that affects the way the body processes blood sugar) with foot ulcer (an open sore, wound, or crater that develops on the skin of your foot) and cellulitis (potentially serious bacterial skin infection) of the left lower limb, and paraplegia (a medical condition characterized by partial or complete paralysis of the lower half of the body). During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool), dated 4/21/2026, the MDS indicated that Resident 15's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were intact with normal thinking and memory function. The MDS indicated Resident 51 requires partial moderate assistance from staff for activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a concurrent interview and record review on 5/20/2026 at 8:42 a.m. with the IP, Resident 51's COVID-19 Vaccine Consent Form, dated 1/28/2026, was reviewed. The COVID-19 Vaccine Consent Form indicated a missing screening section for vaccine eligibility. The IP stated Resident 51's COVID-19 vaccine form was not filled out. The IP stated screening is important to prevent unnecessary double dosing of vaccines. 2b. During review of Resident 50's admission Record, the admission record indicated Resident 50 was initially admitted to facility on 10/10/2025, with diagnoses including leukemia (a group of cancers that affect the blood and bone marrow), DM and keratitis (inflammation of the eye). During a review of Resident 50's MDS, dated [DATE], the MDS indicated Resident 50's cognitive skills for daily decisions were moderately impaired. The MDS indicated Resident 50 required moderate assistance from staff for ADLs. During a concurrent interview and record review on 5/20/2026 at 8:42 a.m. with the IP, Resident 50's COVID-19 Vaccine Consent Form, dated 10/23/2025, was reviewed and indicated a missing screening section for vaccine eligibility. The IP stated Resident 50's COVID-19 vaccine form was not filled out. During a review of the facility's P&P titled, Coronavirus Disease (COVID-19)-Vaccination of Residents, dated 6/2022, the P&P indicated residents are screened for contraindications to the vaccine, medical precautions and prior vaccination before being offered the vaccine.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure each resident's entire drug/medication regime was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being for one of five sampled residents (Resident 11) reviewed for unnecessary medications by failing to monitor for adverse effects (any unwanted, unpleasant, or harmful result caused by a medical treatment) on the use of Xarelto (a prescription blood thinner). This deficient practice could result in increased risk of a broad range of adverse consequences such as bleeding to Resident 11. Cross reference F656. Findings: During a review of Resident 11's admission Record (AR), the AR indicated the facility admitted the resident on 8/31/2016, and readmitted the resident on 4/2/2024, with diagnoses including peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), atherosclerotic heart disease (a condition where the arteries supplying blood to your heart narrow and harden due to a buildup of fatty plaque (cholesterol, calcium, and waste products)), and peptic ulcer (an open sore that develops on the inside lining of your stomach or the upper part of your small intestine (the duodenum)). During a review of Resident 11's History and Physical (H&P), dated 4/18/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 4/1/2026, the MDS indicated the resident had the ability to make self-understood and usually had the ability to understand others and had moderate cognitive impairment (a decline in thinking, memory, or reasoning that interferes with independent daily living). The MDS indicated Resident 11 was on a high-risk drug class anticoagulant (medications that prevent blood clots from forming in the bloodstream). During a review of Resident 11's Order Summary Report (OSR), dated 4/18/2026, the OSR indicated an order for Xarelto oral tablet 10 milligrams (mg, a unit of weight) (Rivaroxaban). Give 1 tablet by mouth one time a day for cerebrovascular accident prophylaxis (CVA PPX, refers to strategies or medications used to prevent a stroke or prevent a recurring stroke). During a concurrent interview and record review on 5/20/2026, at 11:40 a.m., with the Minimum Data Set Coordinator (MDSC), Resident 11's OSR, Care Plans, and Progress Notes were reviewed. The MDSC stated there was no monitoring for adverse effects and no care plan developed and implemented on the use of Xarelto on Resident 11. The MDSC stated monitoring for adverse effects helps the physician to provide safe anticoagulation therapy to assist in properly balancing clotting and anticlotting factors and the care plan was important to ensure safe use of Xarelto. The MDSC stated the care plan serves as a communication tool to all healthcare providers to ensure the use of Xarelto was monitored for adverse effects and to ensure the interventions were provided constantly to meet the set goals. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated it was important to monitor for adverse effect and to develop and implement a care plan on the use of Xarelto to ensure its safe use. The DON stated it was important to monitor for adverse effects of its use so the physician can adjust the dosage of the drug to provide its therapeutic effect and the care plan serves as a communication tool to all healthcare disciplines on what the goal of therapy was and what interventions were set to meet the goal. The DON stated the number one goal of anticoagulant therapy (the use of medications to prevent blood from clotting too easily) was to prevent bleeding to residents. The DON stated the failure of the licensed staff to monitor for adverse effects and to develop and implement a care plan on the use of Xarelto had predisposed the resident to its unsafe use and possibly bleeding. During a review of the facility's recent policy and procedure (P&P) titled, Anticoagulation- Clinical Protocol, last reviewed on 4/23/2026, the P&P indicated under Assessment and Recognition: 1. As part of the initial assessment, the physician and staff will identify individuals who are currently anticoagulated; for example, those with a recent history of deep vein thrombosis (DVT), or heart valve replacement, atrial fibrillation or those who have had recent joint replacement surgery. a. Assess for any signs or symptoms related to adverse drug reactions due to the medication (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alone or in combination with other medications. During a review of the facility's recent P&P titled, Care Plans, Comprehensive Person-Centered, last reviewed on 4/23/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Xarelto (rivaroxaban) tablets for oral use, Xarelto (rivaroxaban) for oral suspension, with initial U.S. approval in 2011, the HPI indicated Warnings and Precautions: -Risk of bleeding. Xarelto can cause serious and fatal bleeding -Pregnancy-related hemorrhage: Use Xarelto with caution in pregnant women due to the potential for obstetric hemorrhage and/or emergent delivery. -Prosthetic heart valves: Xarelto use not recommended -Increased Risk of Thrombosis in Patients with Triple Positive Antiphospholipid Syndrome: Xarelto use not recommended.		

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NAME OF PROVIDER OR SUPPLIER Valley Vista Nursing and Transitional Care LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6120 N. Vineland Ave North Hollywood, CA 91606	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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. During an observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable to one of two Medication Carts (Station 1 Medication Cart 1), by failing to ensure Medication Cart 1 did not have a/an: -Opened glucose test strip (a disposable plastic strip that, when paired with a digital meter, measures the amount of sugar (glucose) in a tiny drop of blood) vial with no open date. -A bottle of Megestrol Acetate Oral Suspension (a prescription liquid medication used primarily as an appetite booster) without an open date. -A new Lantus pen (a pre-filled, disposable device used to inject a long-acting man-made insulin called insulin glargine) mixed with opened insulin pens. The new Lantus pen should have been kept in the refrigerator. -Container of sanitizing wipes mixed with medications. These deficient practices had the potential to administer expired/outdated medications to residents that can cause adverse reactions (an unwanted, unpleasant, or harmful effect caused by a medicine or medical treatment). Findings: During a concurrent observation and interview on 5/21/2026, at 10:30 a.m., with Licensed Vocational Nurse (LVN) 1, in Station 1, Medication Cart 1, observed the following inside the medication cart: -Found 1 vial of opened glucose test strip without the date opened. -Found a bottle of Megestrol Acetate Oral Suspension, USP without an opened fate. -Found 1 new insulin Lantus Pen mixed with opened insulin pens. -Bottom left fourth drawer with medication spills and the bottles of medications were sticky; a container of sanitizer wipes was mixed with the medications. LVN 1 stated the vial of opened glucose strips should be labeled with the date it was opened. LVN 1 stated the test strips are good for 28 days after opening. LVN 1 stated the failure of the staff to label the test strips with an open date had the potential to use outdated test strips that can provide erroneous blood sugar results and improper coverage of insulin. LVN 1 stated the bottle of Megestrol Acetate Oral Suspension should be labeled with an open date. LVN 1 stated the failure of the staff to label the bottle with an open date had the potential for administering expired medications to residents. LVN 1 stated the new Lantus insulin pen should not be mixed with the opened ones and should be kept in the refrigerator. LVN 1 stated the failure of the staff to refrigerate the new insulin pen could result to decrease potency of the drug. LVN 1 stated there was a container of sanitizing wipes mixed with the medications and the drawer had splashes of medications, the medication bottles inside the drawer were sticky. LVN 1 stated mixing chemicals with drugs could potentially make licensed nurses administer the drug that can cause adverse effects on residents, and the dirty drawer can contaminate medications that can potentially cause drug-to-drug interaction on residents. During an interview on 5/21/2026, at 1:52 p.m., with the Director of Nursing (DON), the DON stated the glucose test strip should be open dated and the vial of glucose test strip was only good for 28 days. The DON stated using an outdated test strip could give erroneous results that can be harmful to the resident. The DON stated the Megestrol Oral Suspension should have an open date because once it was opened it will only be good for 30 days. The DON stated that they also use the expiration date whichever comes first. The DON stated the Lantus pen should be refrigerated if new to preserve its potency. The DON stated the disinfectant wipes should not be mixed with the medications as it poses a potential threat of administering them as a medication. The DON finally stated that medication cart drawers should be clean and spill-free to prevent contamination of other medications that when given to the resident can pose a threat of adverse side effects. During a review of the facility's recent policy and procedure (P&P) titled, Storage of Medications, last reviewed on 4/23/2026, the P&P indicated medications and biologicals shall be stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply shall be accessible only to licensed nursing personnel, pharmacy (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	personnel, or staff members lawfully authorized to administer medications. Procedures h. Potentially harmful substances (such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants) shall be clearly identified and stored in a locked area separately from medications. k. Medications requiring refrigeration or temperatures between 2 degrees C (36 degrees F) and 8 degrees C (46 degrees F) shall be kept in a refrigerator with a thermometer to allow temperature monitoring. Medications requiring storage in a cool place shall be refrigerated unless otherwise directed on the label. Refrigerators are checked at least one per day about 24 hours apart. Freezer temperatures shall be kept between -25 degrees C (-13 degrees F) and -10 degrees C (-14 degrees F). m. Inhalers and other unit dose medications shall be kept in closed labeled containers, with internal and external medications separated ii) Once an item is opened, the nurses will write down the open date and it must be discarded according to storage table 1 from the date open. If the item are unit doses, then each individual open pen may have its own date opened and be discarded according to storage table 1 below from the date opened. n. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures shall be immediately removed from stock, disposed of according to procedures for medication disposal (and reordered from the pharmacy if a current order exists). o. Medication storage areas shall be kept clean, well lit, and free of clutter and extreme temperatures. During a review of the facility-provided AgaMatrix Presto Blood Glucose Test Strips, dated 2021, the Information indicated under Storage and Handling: -Do not use AgaMatrix Presto Test Strips beyond the expiration date or 180 days after opening the vial. This may cause inaccurate results. Write the discard date (180 days from the first opening) on the test strip vial.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure residents received palatable and flavorful meals consistent with their preference and nutritional needs for one of one sampled resident (Resident 33). This deficient practice had the potential to decrease Resident 33's appetite, reduce food intake, and negatively affect their nutritional status and quality of life. Findings: During a review of Resident 33's admission Records (AR), the AR indicated the facility originally admitted Resident 33 on 9/29/2022 and readmitted on [DATE] to the facility with diagnoses including moderate protein-calorie malnutrition (the body is not getting enough protein and calories from food, causing weight loss, weakness, loss of muscle, and low energy); metabolic encephalopathy (confusion or changes in thinking caused by a medical problem in the body); dysphagia, oropharyngeal phase (starts in the mouth and cannot swallow properly at the beginning, so food or drink does not go down smoothly). During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 2/18/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (very limited memory, thinking, decision-making and needs help with daily activities). The MDS indicated the resident was dependent to moderate assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated that the resident needs dependent to partial assistance on mobility and ADLs. During an interview on 5/18/2026 at 10:40 a.m. with Resident 33, Resident 33 stated she (Resident 33) does not like the food because the food is not tasty. During an observation and food tray taste test conducted on 5/18/2026 at 2:05 p.m., the meat patty lacked flavor and was bland, the french-fries were dry and unseasoned, and the mixed vegetables were over cooked and mushy. During a concurrent observation and interview on 5/21/2026 at 1 p.m. with Resident 33, observed Resident 33's food tray that contained juice, hot tea, chicken, rice, spinach, soup, a protein shake, and ice cream. Resident 33 stated the chicken did not have flavor and she (Resident 33) did not like the soup. Resident 33 stated that she (Resident 33) did not like the soup because it was bland, and the food is tasteless. Resident 33 stated she (Resident 33) did not want to eat the food anymore and just wanted to eat the ice cream. During an interview on 5/21/2026 at 1:10 p.m. with CNA 5, CNA 5 stated Resident 33 ate about 25% of lunch and normally eats about 25-50%. CNA 5 stated the resident normally drinks protein shakes, but refused today. During an interview on 5/21/2026 at 1:21p.m. with the Dietary Supervisor (DS), the DS stated that the cooks taste the food and follow recipes during meal preparation. The DS stated that if the food is bland, the cooks may add resident-safe seasonings, such as garlic powder or Italian seasoning, but avoid adding salt due to some residents having cardiac conditions. The DS further stated that flavor is important for residents to enjoy their meals, and if residents do not enjoy the food, they may refuse to eat it. The DS stated that when residents complained about the food, the DS asked what the issue was with the food and what foods the residents prefer so changes can be made, if possible, and alternative food options can be offered. The DS stated that Resident 33 likes protein shakes and sweet foods. During a review of the facility-provided Job Description of Head [NAME] indicated that the primary purpose of the job position is to prepare food in accordance with current applicable federal, state, and local standards, guidelines and regulations, with our established policies and procedures, and as may be directed by the Dietitian and/or Director of Food Services, to assure that quality food service is provided at all times. Dietary service Prepare and serve meals that are palatable and appetizing in appearance. During a review of the facility-provided Job Description of [NAME] indicated that the primary purpose of the job position is to prepare food in accordance with current applicable federal, state, and local standards, guidelines and regulations, with our established policies and procedures, and as may be directed by the department of supervisor, to assure that quality food is provided at all times. Specific Job Functions: Prepare and serve meals that are palatable and appetizing. During a review of the facility-provided Job Description of Dietary Aide (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated that the primary purpose of this position is to provide assistance in all dietary functions as directed and in accordance with established dietary policies and procedures. Duties and Responsibilities Serves meals that are palatable and appetizing in appearance.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its antibiotic (ATB - a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic use protocols and a system to monitor antibiotic use for two of four sampled residents (Resident 46 and 66) when the facility failed to: 1. Ensure Resident 46's Ciprofloxacin HCl (a type of antibiotic) Oral Tablet 500 milligrams (mg - a unit of weight) for urinary tract infection (UTI - an infection in the bladder/urinary tract) had monitoring for its adverse effects (an unwanted, harmful, or unpleasant physical or mental reaction caused by a medical treatment, such as a medication or surgery). ^ 2. Ensure there was monitoring for adverse side effects for Resident 66's cephalexin (a widely used prescription antibiotic designed to treat common bacterial infections of the skin, ears, bones, and the urinary or respiratory tracts) use. These deficient practices placed Resident 46 and 66 at risk for unmonitored development of adverse side effects which may result to delay in providing care the resident needs and result in multidrug resistant organisms (MDRO - are types of bacteria or germs that have developed the ability to withstand multiple, common antibiotics that used to kill them) resistance to antibiotics. Findings: 1. During a review of Resident 46's admission Record (AR), the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including UTI, neuromuscular dysfunction of bladder (a breakdown in communication between the brain, spinal cord, and bladder muscles), and punctured wound of abdominal wall. During a review of Resident 46's History and Physical (H&P), dated 4/11/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 46's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate impaired cognition (an intermediate stage of brain decline between normal aging and dementia). The MDS indicated the resident was on high-risk drug class antibiotic. During a review of Resident 46's Order Summary Report (OSR), dated 5/11/2026, the OSR indicated an order for Ciprofloxacin HCl Oral Tablet 500 mg (Ciprofloxacin HCl). Give one (1) tablet by mouth every 12 hours for UTI for seven (7) Days. During a review of Resident 46's Care Plan (CP) Report titled, Resident is on antibiotic therapy related to urinary tract infection and at risk for adverse reaction., initiated on 5/11/2026, the CP indicated an intervention to observed for any side effect or any adverse reactions of antibiotic therapy and call MD once noted. During a concurrent interview and record review on 5/20/2026 at 3:41 p.m. with the Minimum Data Set Coordinator (MDSC), Resident 46's OSR, Progress Notes, and CP were reviewed. The MDSC stated there was an order for Ciprofloxacin HCl Oral Tablet 500 mg (Ciprofloxacin HCl). Give 1 tablet by mouth every 12 hours for UTI for 7 days on the resident's chart however, he (MDSC) cannot find the monitoring for adverse effects on the use of this significant medication. The MDSC stated there was a care plan to monitor for its adverse effects but there was no documentation to support that it was being done. The MDSC stated it was important to monitor for antibiotic Ciprofloxacin adverse effects to ensure its safe use. The MDSC stated monitoring for the adverse effects of the drug (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prevents residents from suffering from harmful effects of the drug for the attending physician to promptly intervene. During an interview on 5/21/2026 at 1:52 p.m. with the Director of Nursing (DON), the DON stated Resident 46's use of Ciprofloxacin should have monitoring for its adverse effects to prevent residents from its harmful effects and the physician can intervene and change the course of antibiotic treatment and prevent antibiotic resistance. 2. During a review of Resident 66's AR, the AR indicated the facility admitted the resident on 2/20/2026 with diagnoses including visual loss both eyes, lack of coordination, and protein-calorie malnutrition (a condition when the body does not get enough nutrition and the body begins to break down its own muscles, fat, and tissues leading to weight loss). During a review of Resident 66's H&P, dated 2/20/2026, the H&P did not indicate Resident 66's capacity to understand and make decisions but had cognitive impairment. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make her needs known. The MDS further indicated Resident 66 had impairment of both upper and required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 66 received antibiotics. During a review of Resident 66's telephone order, dated 5/6/2026, the telephone order indicated the following physician's order: Cephalexin oral tablet 7500 milligrams (mg &ndash; a unit of measurement) give 1 tablet by mouth every six (6) hours for 7 administrations until finished. During a review of Resident 66's care plans (CP) on antibiotic therapy, initiated on 5/6/2026, the CP indicated to administer medication as ordered, monitor the resident's vital signs and notify the physician for abnormal results, and observe for any side effect or any and call the physician once noted as a few of the interventions implemented to keep Resident 66 free of any signs and symptoms of adverse side effects from antibiotic. During a review of Resident 35's progress notes in the electronic health record (EHR) from 5/6/2026 to 5/11/2026, the progress notes did not indicate any monitoring for adverse side effects for the use of cephalexin on the following days and shifts: - 5/6/2026: 11 p.m. to 7 a.m. shift - 5/7/2026: 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m. - 5/8/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. - 5/9/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. - 5/10/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/11/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. During an interview on 5/19/2026 at 11:30 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated if residents are on antibiotic therapy, licensed nurses (LNs) are supposed to monitor the residents for adverse side effects every shift for the duration of the therapy and documented in the progress notes as the residents could have adverse reactions. LVN 2 stated it was important that the residents are not monitored every shift for adverse reactions as it could result in a delay in notifying the physician and result to a delay in resident care. During a concurrent interview and record review on 5/20/2026 at 9:58 a.m. with the MDSC, Resident 66, physician's order, CP, and progress notes were reviewed. The MDSC stated that Resident 66 had an order for cephalexin every 6 hours for 7 administrations until finished dated 5/6/2026. The CP indicated to monitor Resident 66's vital signs and observe for adverse side effects every shift and notify the physician, and that the progress notes did not indicate that Resident 66 was monitored for any adverse side effects on 5/6/2026: 11 p.m. to 7 a.m. shift; 5/7/2026: 3 p.m. to 11 p.m. and 11 p.m. to 7 a.m.; 5/8/2026 to 5/11/2026: 7 a.m. to 3 p.m. to 11 p.m.; 11 p.m. to 7 a.m. The MDSC stated if residents are on antibiotic therapy, the licensed nurses (LNs) are supposed to monitor the residents for adverse side effects every shift for the duration of the therapy plus another 3 days and document in the progress notes as the residents could develop adverse reactions. The MDSC stated that if the residents are not monitored every shift for adverse reactions and develop adverse side effects, it could result in a delay in notifying the physician which could result to the resident not receiving the care needed. The MDSC stated that the LNs should have monitored Resident 66 every shift for adverse side effect for the use of cephalexin as it is considered a high-risk medication and placed Resident 66 at risk for developing adverse side effects that the LNs did not know and could result in a delay in notifying the physician and delay in providing the care Resident 66 needed. During an interview on 5/21/2026 at 2:10 p.m. with the DON, the DON stated that the LNs are supposed to monitor the residents every shift for any adverse side effects with the use of antibiotic such as nausea, vomiting, diarrhea, or allergic reactions for the duration of the antibiotic and document in the progress notes. The DON stated that cephalexin is a significant medication and that monitoring for adverse side effects every shift was important so that the staff can detect immediately and notify the physician so the necessary treatment can be provided to the resident. The DON stated that the LNs should have monitored Resident 66 for development of any adverse side effects every shift and document in the progress notes. The DON stated that if Resident 66 was not monitored every shift, Resident 66 could develop adverse side effects without the staff being aware which could lead to a delay in notifying the physician and providing the necessary care for Resident 66. During a review of the facility's recent policy and procedure (P&P) titled, Antibiotic Stewardship, last reviewed on 4/23/2026, the P&P indicated antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. Policy Interpretation and Implementation 3. Training and education will include emphasis on the relationship between antibiotic use and: a. gastrointestinal (related to the stomach and intestines) disorders; b. opportunistic infections; (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. medication interactions; and d. the evolution of drug-resistant pathogens.ˆ During a review of the facility's P&P titled, Charting and Documentation, last reviewed on 4/23/2026, the P&P indicated that all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) regarding the resident's condition and response to care. The P&P further indicated: - The following information is to be documented in the resident's medical record: a. Objective observations b. Medications administered c. Treatments or services performed d. Changes in the resident's condition e. Events, incidents or accidents involving the resident f. Progress toward or changes in the care plan goals and objectives. - Documentation of procedures and treatments will include care-specific details, including: a. The date and time the treatment/procedure was provided. b. The name and title of the individual(s) who provided the care. c. The assessment date and/or any unusual findings obtained during the procedure/treatment. d. How the resident tolerated the procedure/treatment. e. Whether the resident refused the procedure/treatment. f. Notification of family, physician, or other staff, if indicated.		