STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555165	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for two (2) of four (4) sampled residents (Resident 4 and 8) reviewed and observed for medication administration, in accordance with the facility's policy and procedure (P&P) by failing to ensure:Resident 4's Amiodarone Hydrocholoride (HCL) (used to treat and prevent serious, life-threatening heart rhythm problems) was administered and failing to follow gastrostomy tube (g-tube, surgical procedure wherein a tube is inserted through the abdomen wall and into the stomach used for nutrition and medication administration) flush as indicated on the physician's orderResident 8's Percocet (used to treat moderate to severe pain) was given as indicated on the physician's order. This deficient practice had the potential to increase the risk of Residents 4 and 8 for their health condition to worsen resulting to hospitalization and harm.Findings:1. During a review of Resident 4's Facesheet (admission Record; front page of the chart that contains a summary of basic information about the resident), the Facesheet indicated that the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of hypertension (high blood pressure), hypertensive heart disease with heart failure (a condition where long-term high blood pressure forces the heart to work harder, causing the left ventricle to thicken, stiffen, and eventually weaken), and dementia (a progressive state of decline in mental abilities).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene but was dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating and toileting hygiene.During a review of Resident 4's Physician Orders, dated 9/22/2025, the Physician Orders indicated the following:Amiodarone HCL oral tablet 200 milligrams (mg- unit of measure). Give 1 tablet by mouth one time a day for heart rhythm problems called ventricular arrhythmias (abnormal rhythm of the heart's lower chambers [ventricles] which can reduce blood flow and may be lifeˆthreatening). Amlodipine Besylate (used to treat hypertension [high blood pressure] and certain types of chest pain) oral tablet 5 mg. Give 1 tablet by mouth one time a day for Hypertension. Hold if systolic blood pressure (measures the maximum pressure in your arteries when the heart contracts and beats) is less than 110 or heart rate less than 60.During a review of Resident 4's Physician Order, dated 9/23/2025, the Physician Order indicated to flush g-tube with 30 milliliters (ml- unit of measure) of water before and 30 ml of water after, with 5 ml in between each administration. During a medication administration observation on 3/11/2026 at 8:00 AM, LVN 2 was observed flushing Resident 4's Gˆtube with 15 mL of water before administering medications. LVN 2 was then observed administering Amiodarone via the Gˆtube, during which more (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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	than half of the medication spilled onto the resident. LVN 2 subsequently administered Amlodipine and then Vitamin C without flushing the Gˆtube between medications. LVN 2 was then observed flushing the Gˆtube with 15 mL of water after medication administration. During an interview on 3/11/2026 at 8:30 AM, LVN 2 stated she did not flush Resident 4's gˆtube before and after medication administration with the 30 mL of water as ordered by the physician. LVN 2 also stated she spilled the Amiodarone while administering it to the resident, so the resident did not receive the full dose, which could affect the resident's heart condition. LVN 2 stated she did not flush between administering Amlodipine and Vitamin C. LVN 2 further stated that the physician's order was not followed and that the resident could experience medication adverse effects. 2. During a review of Resident 8's Facesheet, the Facesheet indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), acute kidney failure (the sudden and often reversible loss of kidney function, occurring within hours or days) and pressure Ulcer/injury stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible). During a review of Resident 8's MDS, dated [DATE], the MDS indicated the resident was independent in cognitive skills for daily decision making. The MDS indicated the resident required substantial/maximal assistance with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, but was dependent on lower body dressing and putting on/taking off footwear. The MDS also indicated the resident received pain medications as needed. During a review of Resident 8's Physician Order, dated 3/7/2026, the Physician Order indicated Oxycodone-Acetaminophen (Percocet) oral tablet 5-325. Give 1 tablet by mouth every 8 hours as needed for pain level 8-10. Hold if sleepy or respiratory rate less than 12. During a medication administration observation on 3/11/2026 at 10:10 AM, Resident 8 stated she had a pain level of 7.5 out of 10 (pain scale 0-10; 0 being no pain and 10 being the worst pain). LVN 2 was observed giving Resident 8's Percocet oral tablet 5-325. During an interview on 3/11/2026 at 10:19 AM, LVN 2 stated the Percocet oral tablet 5-325 should not have been given because it was indicated for a pain level of 8-10. LVN 2 stated she did not follow Resident 8's physician's order. During an interview on 3/12/2026 at 8:30 AM, the Assistant Director of Nursing (ADON) stated that the physician's orders regarding flushing during medication administration should be followed. The ADON also stated that it is not acceptable to omit flushing between medications, as the resident may experience adverse drug reactions. The ADON further stated that if a medication is spilled during administration, the resident does not receive the full dosage, and the physician should be notified During a review of the facility's Policy and Procedure (P&P) titled, Specific Medication Administration Procedures, revised 1/2018, the P&P indicated to check the medication administration record to confirm the order: note the medication, dose, route (tube), volume of water for flushing. During a review of the facility's P&P titled, Medication Administration-General Guidelines, revised 12/2019, the P&P indicated medications are administered in accordance with written orders of the prescriber.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure its medication error rate was less than five (5) percent (%). Three medication errors (the observed or identified preparation or administration of medication or biologicals which is not in accordance with the prescriber's order/manufacturer's specifications/accepted professional standards and principles) out of 25 opportunities (observed administered medications) for error which yielded a facility medication error rate of 50% for two (2) of four (4) sampled residents (Residents 4 and 8) observed for medication administration (med pass).Resident 4's Amiodarone Hydrocholoride (HCL) (used to treat and prevent serious, life-threatening heart rhythm problems) was administered and failing to follow gastrostomy tube (g-tube, surgical procedure wherein a tube is inserted through the abdomen wall and into the stomach used for nutrition and medication administration) flush as indicated on the physician's orderResident 8's Percocet (used to treat moderate to severe pain) was given as indicated on the physician's order. These deficient practices had the potential to result in harm to Residents 4 and 8 by not administering medications as prescribed by the physician in order to meet their individual medication needs.Findings:1. During a review of Resident 4's Facesheet (admission Record; front page of the chart that contains a summary of basic information about the resident), the Facesheet indicated that the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of hypertension (high blood pressure), hypertensive heart disease with heart failure (a condition where long-term high blood pressure forces the heart to work harder, causing the left ventricle to thicken, stiffen, and eventually weaken), and dementia (a progressive state of decline in mental abilities).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene but was dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating and toileting hygiene.During a review of Resident 4's Physician Orders, dated 9/22/2025, the Physician Orders indicated the following:Amiodarone HCL oral tablet 200 milligrams (mg- unit of measure). Give 1 tablet by mouth one time a day for heart rhythm problems called ventricular arrhythmias (abnormal rhythm of the heart's lower chambers [ventricles] which can reduce blood flow and may be lifeˆthreatening). Amlodipine Besylate (used to treat hypertension [high blood pressure] and certain types of chest pain) oral tablet 5 mg. Give 1 tablet by mouth one time a day for Hypertension. Hold if systolic blood pressure (measures the maximum pressure in your arteries when the heart contracts and beats) is less than 110 or heart rate less than 60.During a review of Resident 4's Physician Order, dated 9/23/2025, the Physician Order indicated to flush g-tube with 30 milliliters (ml- unit of measure) of water before and 30 ml of water after, with 5 ml in between each administration. During a medication administration observation on 3/11/2026 at 8:00 AM, LVN 2 was observed flushing Resident 4's Gˆtube with 15 mL of water before administering medications. LVN 2 was then observed administering Amiodarone via the Gˆtube, during which more than half of the medication spilled onto the resident. LVN 2 subsequently administered Amlodipine and then Vitamin C without flushing the Gˆtube between medications. LVN 2 was then observed flushing the Gˆtube with 15 mL of water after medication administration. During an interview on 3/11/2026 at 8:30 AM, LVN 2 stated she did not flush Resident 4's gˆtube before and after medication administration with the 30 mL of water as ordered by the physician. LVN 2 also stated she spilled the Amiodarone while administering it to the resident, so the resident did not receive the full dose, which (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	could affect the resident's heart condition. LVN 2 stated she did not flush between administering Amlodipine and Vitamin C. LVN 2 further stated that the physician's order was not followed and that the resident could experience medication adverse effects. 2. During a review of Resident 8's Facesheet, the Facesheet indicated the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), acute kidney failure (the sudden and often reversible loss of kidney function, occurring within hours or days) and pressure Ulcer/injury stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible). During a review of Resident 8's MDS, dated [DATE], the MDS indicated the resident was independent in cognitive skills for daily decision making. The MDS indicated the resident required substantial/maximal assistance with oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, but was dependent on lower body dressing and putting on/taking off footwear. The MDS also indicated the resident received pain medications as needed. During a review of Resident 8's Physician Order, dated 3/7/2026, the Physician Order indicated Oxycodone-Acetaminophen (Percocet) oral tablet 5-325. Give 1 tablet by mouth every 8 hours as needed for pain level 8-10. Hold if sleepy or respiratory rate less than 12. During a medication administration observation on 3/11/2026 at 10:10 AM, Resident 8 stated she had a pain level of 7.5 out of 10 (pain scale 0-10; 0 being no pain and 10 being the worst pain). LVN 2 was observed giving Resident 8's Percocet oral tablet 5-325. During an interview on 3/11/2026 at 10:19 AM, LVN 2 stated the Percocet oral tablet 5-325 should not have been given because it was indicated for a pain level of 8-10. LVN 2 stated she did not follow Resident 8's physician's order. During an interview on 3/12/2026 at 8:30 AM, the Assistant Director of Nursing (ADON) stated that the physician's orders regarding flushing during medication administration should be followed. The ADON also stated that it is not acceptable to omit flushing between medications, as the resident may experience adverse drug reactions. The ADON further stated that if a medication is spilled during administration, the resident does not receive the full dosage, and the physician should be notified During a review of the facility's Policy and Procedure (P&P) titled, Specific Medication Administration Procedures, revised 1/2018, the P&P indicated to check the medication administration record to confirm the order: note the medication, dose, route (tube), volume of water for flushing. During a review of the facility's P&P titled, Medication Administration-General Guidelines, revised 12/2019, the P&P indicated medications are administered in accordance with written orders of the prescriber.

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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 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 follow proper food storage handling practices and infection prevention in accordance with its policy and procedure (P&P) by failing to ensure:1. Dietary Aide 1 (DA 1) was wearing a hair cover (hair net- a protective, typically disposable, mesh or non-woven covering worn over the hair by food service workers to prevent contamination from loose hair and dandruff) while in the kitchen. 2. Two (2) dry food items (a bag of pasta and a bag of sugar) were sealed tightly after being opened.3. One (1) expired dry food items (a bag of grits) were discarded.4. Pots and pans were stored away from the trash can, in a clean and sanitary manner. These deficient practices had the potential to result in food contamination (food that is tainted, spoiled, or contains harmful substances-including microorganisms, chemicals, or foreign objects-that make it unsafe for eating), causing food borne illness (any illness resulting from eating contaminated/spoiled foods) in a population of 57 residents that consumed food by mouth. Findings:1. During a concurrent observation and interview on 3/9/2026 at 7:53 AM with Dietary Aide 1 (DA 1) in the facility kitchen, DA 1 was observed without a hair net with hair exposed. DA 1 stated he should have worn a hair net while in the kitchen to make sure his hair does not get into the food that the resident's consume. During a concurrent interview and record review on 3/9/2026 at 10:35 AM with Dietary Supervisor (DS), the facility P&P titled Dress Code, dated 2023 was reviewed. The P&P indicated the proper dress attire for staff to include hat for short hair to completely cover the hair and a hair net for hair that is long enough to cover the ears or longer. DS stated the facility does not have hats for staff with short hair but per facility policy, DA 1 should have been wearing a hat while in the kitchen. The DS further stated it was important to follow the policy to prevent the staff's hair from going into residents' food during food preparation. DS also stated residents could feel angry, refuse the food, or possibly get illness from contaminated food. During a review of the facility's P&P titled Dietary Department- Infection Control, dated 6/4/2024, the P&P indicated personal cleanliness is required in sanitary food preparation and hair will be covered with an effective hair restraint (hair cover) while in any kitchen and food storage areas. 2. During an observation on 3/9/2026 at 8:05 AM with DS in the facility kitchen, one (1) bag of sugar and 1 bag of dried pasta was observed open and not tightly sealed. DS stated the bag of sugar and bag of pasta was opened and unsealed and should have been sealed after opening. During a concurrent interview and record review on 3/9/2026 at 10:40 AM with DS, the facility P&P titled Storage of Food and Supplies, dated 2023 was reviewed. The P&P indicated that dry foods including a bag of pasta that have been opened will be stored in a sealed container or the bag will be sealed tightly, labeled with the date it was opened. DS stated per facility P&P the opened bag of pasta and opened bag of sugar should have been resealed individually after being opened to prevent contamination from bugs and/or other food particles. DS further stated residents can get a food borne illness, diarrhea, stomach cramps from eating contaminated foods. 3. During a concurrent observation and interview on 3/9/2026 at 8:28 AM with DS at the facility's dry storage closet, a bag of grits labeled with an expiration date of 6/3/2025 was observed. DS stated the bag of grits is expired and should have been thrown away to prevent it from being given to residents and possibly causing residents to get sick if the grits was served and eaten by the residents. During a review of the facility's P&P titled, Storage of Food and Supplies, dated 2023, the P&P indicated food, and supplies will be stored properly and in a safe manner. 4. During an observation on 3/9/2026 at 8:10 AM with DS in the facility kitchen, a trashcan was observed under the sink next to clean skillets, pots and baking pans. DS stated there used to be a plastic divider to create a barrier between the trashcan and the clean skillets, pots and baking pans, but it broke and the facility has not replaced it. During an observation on 3/11/2026 at 12:47 PM in the facility kitchen, the trashcan located next to the clean skillets, pots and baking pans was observed with trash overflowing past the top rim. The trashcan lid was observed leaning and resting onto a stack of clean (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	baking pans, and food waste particles were observed splashed onto the stack of clean baking pans. During an interview on 3/11/2026 at 2:28 PM with DS, DS stated the trashcan should not be stored next to clean dishes, cooking wares and/ or baking ware because trash can get on the clean dishes and contaminate the food once used, causing residents to get sick. During a review of the facility's P&P titled, Dietary- Infection Control, dated 6/4/2024, the P&P indicated dietary employees will follow Infection Control P&P as established and approved by the Infection Control Committee, and to ensure that the dietary department is maintained in a sanitary condition in order to prevent food contamination and the growth of disease producing organism and toxins.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure all the food items brought into the facility by visitors for residents were labeled and dated with the resident's name as indicated in the facility's policy titled Food Brought in by Visitors,. This failure had potential for residents to receive and consume the food of another resident and/or not receive their food brought into the facility. Findings:During an observation on 3/9/2026 at 9:51 AM with Dietary Supervisor (DS) in the facility Activity Room, three (3) food containers not labeled with the resident's name were observed in the resident's refrigerator (refrigerator used only for personal food items [NAME] to the facility by family and/or friends). DS stated the 3 food containers did not have a resident's name labeled on the container. During a concurrent interview and record review on 3/9/2026 at 10:35 AM with DS, the facility policy titled Food Brought in by Visitors, dated 5/22/2025, was reviewed. The policy indicated food may be brought to a resident by visitors and facility staff will place the food in a food container that is clearly labeled with the resident's name and date received and stored in a designated refrigerator. DS stated the residents' food items should be labeled with the resident's name that the food belonged to. DS also stated it was important to follow the policy to prevent staff from mistaken one resident's food for another resident and to make sure the residents get their correct food. DS further stated if the food is labeled improperly and given to the wrong residents, residents can get sick and their safety can be compromised because it could be the wrong diet and/or food texture.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain an informed consent (is the act of agreeing to allow something to happen, or to do something, with a full understanding of all the relevant facts, including risks, and available alternatives)) prior to administering psychotropic medications (substance that affects the brain and alters mood, perception, behavior, or consciousness) for two (2) of five (5) sampled residents (Resident 1 and 28) reviewed for unnecessary medications in accordance with the facility policy when:Resident 1 did not have an informed consent prior to the use of antidepressant (prescription drugs designed to alleviate the symptoms of depression and other mental health conditions).Resident 28 did not have an informed consent prior to the use of antipsychotic (medication used to treat psychosis [a serious mental disorder characterized by defective or lost contact with reality]) and antidepressant.This deficient practice had the potential for Residents 1 and 28 not to be able to exercise the right to choose their treatment plan.Findings:1. During a review of Resident 1's Facesheet (admission Record), the Facesheet indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and chronic kidney disease (long-term, progressive loss of kidney function, often caused by diabetes or high blood pressure). During a review of Resident 1's History and Physical (H&P), dated 1/22/2026, the H&P indicated the resident has the capacity to understand and make decisions.During a review of Resident 1's Informed Consent form for Trazodone Hydrocholoride (HCL) (medication used for depression) tablet 50 milligrams (mg-unit of measure), dated 7/27/2025, the form did not have Resident 1's signature indicating resident consented to the use of Trazodone HCL. During a review of Resident 1's Physician Order, dated 1/21/2026, the Physician Orders indicated Trazodone HCL. Give 1 tablet by mouth at bedtime for depression as manifested by inability to sleep. During a review of Resident 1's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/2026, the MAR indicated Resident 1 received the medication from 3/1/2026 to 3/11/2026. During a concurrent review of Resident 1's consent form and interview on 3/12/2026 at 8:40 AM with the Assistant Director of Nursing (ADON), the ADON stated Resident 1 was self-responsible and the facility should obtain a consent from the resident prior to placing an order for an antidepressant. ADON stated the consent form for Trazodone HCL was not signed by Resident 1. During an interview on 3/12/2026 at 11AM, Resident 1 stated he did not give or sign a consent for Trazodone HCL. 2. During a review of Resident 28's Facesheet, the Facesheet indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of heart failure, and obstructive and reflux uropathy (a blockage in the urinary tract preventing proper drainage, while reflux uropathy is the backward flow of urine toward the kidneys [organs that remove waste from the body via urine]) During a review of Resident 28's Physician Order, dated 12/17/2026, the Physician Order indicated Doxepin HCL (medication for depression) capsule 100 mg. Give 1 capsule by mouth at bedtime for depression as manifested by inability to sleep. During a review of Resident 28's Informed Consent for Aripiprazole (antipsychotic) 5mg and Doxepin HCL 100 mg, dated 12/18/2025, the form did not have Resident 28's signature indicating resident consented to the use of Aripiprazole and Doxepin HCL. During a review of Resident 28's H&P, dated 12/19/2025, the H&P indicated the resident has the capacity to make medical decisions. During a review of Resident 28's Physician Order, dated 12/23/2026, the Physician Order indicated Aripiprazole Oral Film 5mg Give 1 tablet by mouth in the morning for schizophrenia as manifested by verbal aggression as evidenced by anger outburst. During a review of Resident 28's MAR, dated 3/2026, the MAR indicated Aripiprazole was given from 3/1/2026 to 3/12/2026. The MAR also indicated Doxepin was given from 3/1/2026 to (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/2026. During a concurrent review of Resident 28's consent form and interview on 3/12/2026 at 8:40 AM with the ADON, the ADON stated Resident 28 was self-responsible and the facility should obtain consent from the resident prior to placing an order for an antidepressant and antipsychotic medications. The ADON also stated the consent was not signed by the resident. During an interview on 3/12/2026 at 11:05AM, Resident 28 stated he did not give or sign a consent for Aripiprazole and Doxepin HCL. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rights, dated 1/14/2026, the P&P indicated the resident should be informed about what rights he/she has. The P&P also indicated the resident has the right to choose treatment and participate in decisions. During a review of the facility's P&P titled, Informed Consent, dated 1/30/2026, the P&P indicated if the resident is determined to have capacity, the resident may provide informed consent.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Park Skilled Nursing and Wellness Center	5125 Monte Vista St. Los Angeles, CA 90042

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to maintain a comfortable, safe and homelike environment for one (1) of 20 sampled residents (Resident 28) by failing to ensure resident's room did not have crack and peeled off paints on the walls. This deficient practice had the potential for Resident 28 to have increased level of discomfort which can impact the resident's quality of life. Findings:During a review of Resident 28's Facesheet (admission Record), the Facesheet indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of heart failure, and obstructive and reflux uropathy (a blockage in the urinary tract preventing proper drainage, while reflux uropathy is the backward flow of urine toward the kidneys [organs that remove waste from the body via urine]). During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool), dated 12/24/2025, the MDS indicated the resident is independent in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene, shower/bath self, upper body dressing, lower body dressing and putting on/taking off footwear. During a concurrent observation and interview on 3/9/2026 at 9:16 AM, Resident 28 stated the cracks in the walls and the peeled off paint makes him feel uncomfortable because the resident thinks spiders can come out from the cracks. During an interview on 3/12/2026 at 9:05 AM, Assistant Director of Nursing (ADON) stated the cracked walls, and peeled paint is not ok because that is not safe, sanitary and home like for the resident. ADON also stated there could be bugs/ spiders coming out of the cracks in the walls. During a review of the facility's Policy and Procedure (P&P) titled, Resident Rooms and Environment, revised 1/14/2026, the P&P indicated the facility will provide residents with a pleasant environment and person-centered care that emphasizes the resident's comfort, independence, and personal needs and preferences. The P&P also indicated to provide residents with a safe, clean, comfortable and homelike environment.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure that the depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) behaviors for one (1) of 20 sampled residents (Resident 9), was monitored and documented as ordered while the resident is receiving Remeron (a medication used to treat depression). This failure had the potential for Resident 9 to receive an unnecessary psychotropic medication (the use of drugs that alter brain chemistry to treat mental health conditions by managing mood, thoughts, and behavior, that are inappropriate for a patient's condition, taken in excessive doses, or used to manage behaviors for staff convenience rather than treating a specific, documented diagnosis). Findings:During a review of Resident 9's admission Record, the admission Record indicated Resident 9 was readmitted to the facility on [DATE] with diagnoses that included depression, chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or reduced control on one side of the body, affecting the arm, leg, and face). During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2026, the MDS indicated Resident 9 had moderately impaired cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 9 was dependent (helper does all the effort) for toileting hygiene, shower/bathing self, partial/moderate assistance (helper does less than half the effort) for oral hygiene and setup or clean-up assistance (helper sets up or cleans up) with eating. The MDS also indicated Resident 9 was receiving an antidepressant medication. During a review of Resident 9's Order Summary Report, dated 3/10/2026, the Order Summary Report indicated staff to monitor target behaviors for use of Remeron due to depression manifested by poor oral intake of less than 50 percent, indicate the number of behavior occurrences; if no behaviors, select not applicable. During a concurrent interview and record review on 3/12/2026 at 1:54 PM with Licensed Vocation Nurse 1 (LVN 1), Resident 9's Medication Administration Record (MAR), dated 3/1/2026 through 3/31/2026 was reviewed. The MAR indicated staff to monitor and document the number of Resident 9's behavior occurrences every shift. The MAR indicated a check mark for each entry for the day, evening and night shift on 3/10/2026 and 3/11/2026. The MAR did not indicate a numeric value for Resident 9's behavioral occurrences. LVN 1 stated according to Resident's physician's order, the facility should have monitored and documented a number for how many times the resident's behavior occurred, but licensed staff did not. LVN 1 stated the check mark documented was for yes or no, and it was important to monitor and document a number so that the psychiatrist and interdisciplinary team can determine if the medication is effective or if other interventions need to be done like increase or decrease the dose. During an interview on 3/12/2026 at 2:22 PM with Assistant Director of Nursing (ADON), ADON stated licensed staff should be using hash marks (numbers) when monitoring Resident 9's depression behavioral occurrences and document in the resident's MAR so that the resident's care team can monitor if the resident's behavior is improving. During a review of the facility's policy and procedure (P&P) titled, Behavior/Psychoactive Drug Management, dated 1/14/2026, the P&P indicated the facility will provide person-centered, comprehensive, and interdisciplinary care that reflects best practice standards for meeting health, safety, psychosocial, behavioral, and environmental needs of residents; to provide a therapeutic environment that supports residents to obtain or maintain the highest physical, mental and psychosocial well-being.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete the Preadmission Screening and Resident Review (PASARR - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) Level 1 Screening accurately for one of one sampled residents (Resident 2) reviewed for PASARR. This resulted in an inaccurate evaluation that Resident 2 did not require a Level 2 PASARR, with the potential for Resident 2 not to receive the appropriate level of care Findings:During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was originally admitted to the facility on [DATE] with diagnoses that included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), schizophrenia (a mental illness that is characterized by disturbances in thought) and epilepsy (a chronic brain disorder characterized by recurring, unprovoked seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] caused by abnormal electrical activity). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 12/15/2024, the MDS indicated Resident 2's most recent entry date was on 12/7/2024. The MDS also indicated Resident 2 had depression, schizophrenia, and was taking antipsychotic and antidepressant medications during the last 7 days or since admission. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognitive skills (ability to understand and make decisions) for daily decision making. The MDS indicated Resident 2 was independent with eating and oral hygiene. The MDS indicated Resident 2 required set up or clean assistance with toileting hygiene, shower/bathe self, dressing, personal hygiene and sit to lying and required supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with walking. During a review of Resident 2's PASARR Level 1 Screening, dated 12/7/2024, the PASARR Level 1 Screening indicated the Level 1 Screening was completed by facility staff who documented Resident 2 was not diagnosed with a serious mental illness (SMI) nor that Resident 2 was prescribed any psychotropic medications (medications that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). The PASARR Level 1 Screening also indicated with the submitted information, Resident 2 was negative for SMI and a Level 2 PASARR Evaluation was not required. During a concurrent review of Resident 1's PASARR Level 1 dated 12/7/2024 and interview on 3/11/2026 at 10:51 AM with the MDS Nurse (MDSN), the MDSN stated Resident 2 was readmitted on [DATE] so another PASARR Level 1 screening was completed on 2/7/2024. MDSN stated Resident 2's PASARR was not accurate since it did not reflect that Resident 2 had a diagnosis of schizophrenia and was receiving three psychotropic medications. The MDSN also stated it was important that Resident 2's PASARR Level 1 Screening was completed accurately to ensure Resident 2 was evaluated to see if he would require any special services and if the facility can meet his needs. During an interview on 3/12/2026 at 2:24 PM with the Assistant Director of Nursing (ADON), the ADON stated a PASARR is a behavioral [health] evaluation of the diagnoses and medications of a resident and to assess them for special services that may be needed. The ADON also stated the PASAR Level 1 Screening needs to be done accurately to ensure continuity of behavioral care and medications. The ADON stated Resident 2's PASARR Level I Screening done on 12/4/2024, was not accurate so facility cannot ensure all of his needs are being met. During a review of the facility policy and procedure (P&P) titled, Pre-admission Screening Resident Review (PASRR), dated 1/14/2026, the P&P indicated all residents are to be screened for mental illness and intellectual disability (ID) or a related condition (RC). The P&P also indicated the facility staff will complete a new PASRR if there has been a significant change in the resident's condition. During a review of the facility's P&P titled, admission Screening Resident Review (PASRR), dated 1/14/2026, the P&P indicated the facility MDS coordinator will be responsible for accessing and ensuring updates to the PASRR are completed per MDS guidelines.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop an individualized resident-centered care plan (a care plan that prioritizes the unique health needs and desired outcomes of the resident) for two (2) of 20 sampled residents (Residents 21 and 46) by failing to:Include resident centered interventions to address Resident 21's risk for fall. This deficient practice has the potential to increase Resident 21's risk for falls resulting in incidents of fall and injury. Reflect Resident 46's fluid restriction as indicated on the physician's order. This deficient practice has the potential for Resident 46's fluid restriction not to be followed, which could result in respiratory complications, cardiovascular strain and fluid overload. Findings: 1. During a review of Resident 21's admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of difficulty walking, lack of coordination, and history of falls. During a review of Resident 21's Minimum Data Set (MDS – a resident assessment tool), dated 2/3/2026, the MDS indicated the resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident was dependent (helper does all of the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 21's Fall Risk Assessment, dated 1/27/2026, the assessment indicated Resident 21's fall risk score was 5. During an interview on 3/12/2026 at 11:38AM, Licensed Vocational Nurse 2 (LVN 2) stated the resident has a tendency to get up on her own unassisted. During a concurrent review of Resident 21's Fall Risk Assessment, dated 1/27/2026, and interview on 3/12/2026 at 11:42 AM with the Assistant Director of Nursing (ADON), the ADON stated Resident 21's Fall Risk Assessment fall score of 5 means the resident is at low risk for falls. During the same concurrent review and interview on 3/12/2026 at 11:42 AM with ADON, Resident 21's Fall Risk Care Plan, dated 1/28/2026, was reviewed. The ADON stated to make the care plan more resident centered the interventions for Resident 21 should have included the following, especially since the resident has a tendency to get up on her own unassisted: 1. Do rounds more often due to the resident getting up on her own 2. Offer snacks during snack time or as requested by the resident. 2. During a review of Resident 46's admission Record, the admission Record indicated Resident 46 was admitted to the facility on [DATE] and readmitted to on 11/19/2025, with diagnoses that included end stage renal disease (a permanent condition that occurs when the kidneys are no longer able to function and require dialysis or a kidney transplant to survive), dependence on renal dialysis [(a state of requiring dialysis, (a type of treatment that helps your body remove extra fluid and waste (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	products from your blood when the kidneys are not able to) to maintain life], unspecified atrial fibrillation (an irregular and often very rapid heart rhythm), and unspecified anemia (a problem of not having enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). During a review of the MDS, dated [DATE], the MDS indicated Resident 46 had no impairment for cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 46 needs supervision or touching assistance, (helper provides verbal cues and /or touching/steadying and/or contact guard assistance as resident completes activity) for toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, sit to lying and sit to stand. Resident 46 needs set up or clean-up assistance, (helper sets up or cleans up; resident completes activity. Helper assists only prior to or following the activity) for eating and oral hygiene. During a review of Resident 46's Physician Orders, dated 2/5/2026, the Physician Orders indicated a fluid restriction of 1000 milliliter (ml, a measurement of fluid volume) per day, as follows: - Dietary 360 ml (for meals): 120 ml fluid intake for each meal. - Nursing 640 ml: 240 ml for 7AM -3PM (AM shift), 240 ml for 3PM to 11 PM (PM shift), and 160 ml for 11PM to 7AM. (NOC shift) During a concurrent interview and record review on 3/11/2026 at 11:07 AM with Licensed Vocational Nurse 2 (LVN2), Resident 46's care plan report was reviewed. The care plan did not reflect Resident 46's fluid restriction of 1,000 ml as indicated in the physician's order dated 2/5/2026. LVN 2 stated a resident centered care plan was important to prevent Resident 46 from dangerous fluid buildup in the lungs, heart, and tissues between treatments. During an interview on 3/11/2026 at 11:26 AM, the ADON stated it was very important for nurses to develop a resident centered care plan for Resident 46 to reflect the resident's fluid restriction to prevent hypertension (chronic elevated blood pressure), dangerous heart strain, and shortness of breath from fluid buildup to Resident 46. During a review of the facility's Policy and Procedure (P&P) titled, Comprehensive Person-Centered Care Planning, revised 1/14/2026, the P&P indicated the care plan must include the minimum healthcare information necessary to properly care for each resident such as health and safety concerns to prevent decline or injury. The P&P also indicated additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident (Resident 5) reviewed for hearing received proper treatment to improve hearing abilities by failing to follow up with Resident 55's authorization for audiogram (measures hearing sensitivity across different pitches and volume to detect hearing loss) and tympanogram (assess middle ear function [eardrum movement, fluid, pressures]) (non-invasive diagnostic tests used to evaluate ear health) after the resident's Ears, Nose and Throat (ENT) appointment on 1/21/2026. This deficient practice had the potential for Resident 55 to have increased hearing loss.Findings: During a review of Resident 55 Facesheet (admission Record), the Facesheet indicated the resident was admitted to the facility on [DATE] with the following but not limited to diagnoses of hypertension (high blood pressure), history of falling, and difficulty in walking. During a review of Resident 55 Minimum Data Set (MDS - a resident assessment tool), dated 1/6/2026, the MDS indicated the resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 55 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with toileting hygiene and upper body dressing but required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with shower/bathe self, lower body dressing and putting on/ taking off footwear. During a review of Resident 55 Physician Order, dated 12/30/2025, the Physician Order indicated audiology consults with follow up treatment as indicated. During a concurrent observation and interview on 3/9/2026 at 10 AM, Resident 55 stated she is hard of hearing and cannot hear what Surveyor 1 is saying. During a concurrent review and interview with Social Services Director (SSD) on 3/11/2026 at 12:44 PM, Resident 55's ENT, dated 1/21/2026, was reviewed. The ENT indicated plan to recommend audiological testing and follow up after audio testing. ENT also indicated authorization for audio and tympanogram and audio follow up. SSD stated she did not and should have followed up on Resident 55's ENT authorization to ensure the resident hearing does not decline.During an interview on 3/12/2026 at 9 AM, Assistant Director of Nursing (ADON) stated after the ENT appointment, the authorization for audio and tympanogram should be followed up to ensure the resident's hearing does not decline. ADON also stated Resident 1 did not and should have had a care plan for hard of hearing. During a review of the facility's Policy and Procedure (P&P) titled, Referrals to Outside Services, revised 1/14/2026, the P&P indicated the Director of Social Services coordinates the referral of residents to outside agencies to fulfill resident needs for services. The P&P also indicated the Director of Social Services is responsible for locating agencies and programs that meet the resident's needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide supervision for one (1) of 1 sampled resident (Resident 29) reviewed for smoking when Resident 29 was observed smoking by himself outside in the patio.This deficient practice has the potential for safety concerns and accidents for Resident 29. Findings: During a record review of Resident 29's Facesheet (Admissions Record), the Facesheet indicated the resident was originally admitted to the facility on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of difficulty in walking, lack of coordination and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 29's Minimum Data Set (a resident assessment tool), 1/15/2026, the MDS indicated the resident was moderately impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated Resident 29 required partial/ moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs but provides less than half the support) with toileting hygiene, shower/bath self, upper body dressing, lower body dressing and putting on/taking off footwear. During a review of Resident 29's Care Plan with focus on chronic tobacco use, revised 2/18/2026, the Care Plan indicated the resident requires supervision while smoking, and staff to keep smoking material for safekeeping.During a review of the facility's Smoke Break Assignment, dated 3/11/2026, the Smoke Break Assignment indicated the Admissions Coordinator (AC) will supervise the residents during smoke break starting at 11AM. During an observation on 3/11/2026 at 11:20 AM outside the patio, Resident 26 was observed smoking outside with no supervision. During an interview on 3/11/2026 at 11:43AM, the AC stated he did not observe Resident 29 while he was smoking. AC also stated Resident 29 requires supervision and it was not acceptable that Resident 29 smoked without supervision for safety reasons and to prevent accidents. During an interview on 3/12/2026 at 8:56AM, the Assistant Director of Nursing (ADON) stated Resident 29 requires supervision while smoking. ADON also stated it was not acceptable that Resident 29 was not being supervised while smoking because the resident could injure himself or cause a fire. During a review of the facility's Policy and Procedure (P&P) titled, Smoking Residents, revised 1/14/2026, the P&P indicated the interdisciplinary team (consists of healthcare professionals from diverse specialties [e.g., physicians, nurses, social workers, therapists] working collaboratively to provide comprehensive, patient-centered care) will develop an individualized plan of care for safe storage, use of smoking materials, assistance, and/ or requires supervision, for residents who smoke. Durin a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, revised 1/14/2026, the P&P indicated the care plan should address resident specific health and safety concerns to prevent decline or injury and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living as necessary. The P&P also indicated when a care plan is developed, it is implemented.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the fluid restriction (a dietary change that limits the amount of liquid a person can consume in a day) as indicated on the physician order for one (1) of two (2) sampled residents (Resident 13), who were receiving dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney/s have failed) treatment. This deficient practice has the potential to cause fluid overload (a condition where there is too much fluid in the body which could result in swelling, particularly in the ankles and legs, shortness of breath and health complications) to Resident 13. Findings:During a review of Resident 13's Facesheet (admission Record), the Facesheet indicated the resident was originally admitted at the facility on 3/19/2024 and was readmitted on [DATE] with the following but not limited to diagnoses of End Stage Renal Disease (ESRD - the final, irreversible stage of kidney [they are vital for filtering waste, excess fluid, and toxins from the blood to produce urine] failure where kidney function declines to below 15% of normal), cognitive (the ability to understand and make decisions) communication deficit and dependence on renal (refers to the kidneys) dialysis. During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool), dated 1/9/2026, the MDS indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS also indicated, Resident 13 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with eating, and oral hygiene but is dependent (helper does all of the effort. The MDS indicated Resident 13 does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) with toileting hygiene, shower/bathe self, upper body dressing, lower body dressing and putting on/taking off footwear. In addition, the MDS indicated the resident has dialysis as a special treatment. During a review of Resident 13's Physician Orders, dated 1/2/2026, the Physician Orders indicated fluid restriction of 1000 milliliters (ml-unit of measure) per day. During a review of Resident 13's Care Plan with focus on dialysis, revised 3/7/2026, the Care Plan indicated a fluid restriction of 1000 ml per day. During a review of Resident 13's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 3/2026, the MAR indicated fluid restriction 1000 ml per day. The MAR also indicated on 3/1/2026, Resident 13 received 640 ml for the morning shift, 240 ml for the evening shift and 160 ml for the night shift with a total of 1,040 ml. During an interview on 3/11/2026 at 3 PM, Assistant Director of Nursing (ADON) stated Resident 13's MAR indicated Resident 13 received 1,040 ml of fluid on 3/1/2026 which is more than the fluid restriction order for the resident. During a concurrent interview and record review on 3/12/2026 at 8:51 AM, facility's Policy and Procedure (P&P) titled, Dialysis Management, dated 1/14/2026, was reviewed. The P&P indicated diet and fluid restrictions will be followed as ordered. ADON stated it is not ok that Resident 13 received fluids that were over the fluid restriction limit and the resident can get fluid overload.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one (1) of four (4) sampled residents (Resident 4) reviewed and observed for medication administration was free from significant medication error (the identified preparation or administration of medication was not in accordance with the physician's order, which may have cause the resident discomfort or jeopardize health and safety) by failing to administer Resident 4's Amiodarone Hydrocholoride (HCL) (used to treat and prevent serious, life-threatening heart rhythm problems) as indicated on the physician order.This deficient practice placed Resident 4 at risk of not getting the full effect of the medication which can result in blood pressure and heart rhythm problems.Findings:1. During a review of Resident 4's Facesheet (admission Record; front page of the chart that contains a summary of basic information about the resident), the Facesheet indicated that the resident was originally admitted on [DATE] and was readmitted on [DATE] with the following but not limited to diagnoses of hypertension (high blood pressure), hypertensive heart disease with heart failure (a condition where long-term high blood pressure forces the heart to work harder, causing the left ventricle to thicken, stiffen, and eventually weaken), and dementia (a progressive state of decline in mental abilities).During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated the resident was severely impaired in cognitive (the ability to understand and make decisions) skills for daily decision making. The MDS also indicated the resident required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with oral hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene but was dependent (helper does all the effort. Resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity) with eating and toileting hygiene. During a review of Resident 4's Physician Orders, dated 9/22/2025, the Physician Orders indicated Amiodarone HCL oral tablet 200 milligrams (mg- unit of measure). Give 1 tablet by mouth one time a day for heart rhythm problems called ventricular arrhythmias (abnormal rhythm of the heart's lower chambers [ventricles] which can reduce blood flow and may be lifeˆthreatening). During a medication administration observation on 3/11/2026 at 8:00 AM, LVN 2 was observed administering Amiodarone to Resident 4 via the Gˆtube, during which more than half of the medication spilled onto the resident. During an interview on 3/11/2026 at 8:30 AM, LVN 2 stated she spilled the Amiodarone while administering it to the resident, so the resident did not receive the full dose, which could affect the resident's heart condition. LVN 2 further stated that the physician's order was not followed and that the resident could experience medication adverse effects. During an interview on 3/12/2026 at 8:30 AM, the Assistant Director of Nursing (ADON) stated if a medication is spilled during administration, the resident does not receive the full dosage, and the physician should be notified. During a review of the facility's Policy and Procedure (P&P) titled, Specific Medication Administration Procedures, revised 1/2018, the P&P indicated to check the medication administration record to confirm the order: note the medication, dose, route (tube), volume of water for flushing. During a review of the facility's P&P titled, Medication Administration-General Guidelines, revised 12/2019, the P&P indicated medications are administered in accordance with written orders of the prescriber.

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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. Based on observation, interview and record review, the facility failed to ensure safe provision of pharmaceutical services as indicated in the facility policy by failing to refrigerate two unopened latanoprost eye drops (medication used to lower high pressure in the eye) in accordance with the facility policy. This deficient practice increases the risk of the residents receiving a medication that had become ineffective or toxic due to improper storage, possibly leading to health complications resulting in damage to the optic nerve (a bundle of over one million nerve fibers that transmits visual information from the retina to the brain, acting as the sole communication path for sight) and potential vision loss or blindness.Findings:During a medication cart observation and interview on 3/12/2026 at 7:54 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 7 and 36's latanoprost eye drops were observed inside the medication cart. LVN 1 stated the eye drops should be stored in the refrigerator designated for medication storage until they are open in accordance with the manufacturer's instruction, so the medication can remain potent (effective). During an interview on 3/12/2025 at 8:36 AM, Assistant Director of Nursing (ADON) stated the 2 bottles of latanoprost eye drops should be in the refrigerator until they are open to maintain the medication's potency. ADON also stated the eye drop in the medication cart may not be as effective and may be toxic for the resident. During a review of the facility's Policy and Procedure (P&P) titled, Medication Storage in the Facility, revised 9/2018, the P&P indicated medications requiring refrigeration are kept in the refrigerator at temperatures between 36 F Fahrenheit ([F- represents temperature value] is equivalent to 2 Celisus [C - represents temperature value]) and 46 F (8 C) with a thermometer to allow temperature monitoring. During a review of the facility's P&P titled, Medication Administration - General Guidelines, revised 12/2019, the P&P indicated medications should be properly oriented to the facility's medication distribution system including storage of medications. During a review of the food and drug administration (FDA) full prescribing information for Xalatan (latanoprost) Ophthalmic Solution, revised 12/2022, the information indicated protect the medication from light and store unopened bottle(s) under refrigeration at 2 to 8 C (36 to 46 F).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure one (1) of twenty (20) sampled residents (Resident 37) breathing treatment mask and tubing (deliver aerosolized medication directly to the lungs. It includes vinyl mask, medication cup and plastic tube), and respiratory set up bag was changed every seven days per facility's policy and procedure. This failure had the potential to cause respiratory tract (airways including lungs) infection which can lead to Resident 37's hospitalization. Findings: During a review of Resident 37's admission Record indicated Resident 37 was admitted to the facility on [DATE] and readmitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease (a progressive lung disease that makes it difficult to breathe) , presence of cardiac (an electronic device that is implanted in the body to monitor heart rate and rhythm), paroxysmal atrial fibrillation (a type of irregular heart rhythm that starts and stops suddenly, with episodes lasting less than seven days). During a review Resident 37's Minimum Data Set (MDS- a resident assessment tool)- dated 1/31/2026, indicated Resident 37 was assessed to have moderately impaired (decisions poor: cues/supervision required) for cognitive skills (mental processes that allow people to think, learn, and solve problems) for daily decision making. The MDS also indicated Resident 37 is dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, lower body dressing, and personal hygiene and Resident 37 needed substantial/maximal assistance in roll left and right, sit to lying and sit to stand. During a review of Resident 37's Physician Orders, dated 2/27/2026, it indicated Resident 37 has an order for Ipratropium bromide inhalation solution (a sterile, preservative-free, short-acting bronchodilator solution used in a nebulizer machine [a medical device that converts liquid medication into a fine mist {aerosol}, allowing it to be inhaled directly into the lungs through a mouthpiece or face mask], to treat shortness of breath, wheezing, and COPD symptoms by opening airways) 0.5 milligram (mg a unit of measurement)/2.5 milliliter, (ml- a metric unit for measuring liquid volume) inhale orally via nebulizer every twelve hours for wheezing (an uncomfortable feeling of not getting enough air, and a high-pitched whistling sound caused by narrowed airways). During an observation on 3/11/2026 at 8:33 AM in Resident 37's room, observed Resident 37's breathing treatment mask and tubing (some parts of the tubing was outside the bag) was stored inside a respiratory set up bag dated 3/1/2026. There was no date of first use labeled on the breathing treatment mask nor the tubing beside the date on the respiratory set up bag. The parts of the tubing that was left hanging outside the respiratory set up bag were touching the floor. During an interview on 3/11/2026 at 9:45 AM with Licensed Vocational Nurse (LVN1), LVN 1 stated Resident 37's breathing treatment mask, tubing and respiratory/ patient set up bag are supposed to be changed every seven days by morning shift nurses to help prevent infection. LVN 1 stated, the label on the respiratory set up bag was dated 3/1/2026 and the breathing treatment mask, tubing and respiratory t set up bag should have been changed on 3/8/2026 but it was not changed. LVN 1 also stated changing breathing treatment mask, tubing and respiratory set up bag is to prevent the accumulation of bacteria and germs that can cause lung or respiratory infection. During an interview on 3/11/2026 at 10:05 AM with Infection Preventionist Nurse (IP), IP nurse confirmed the breathing treatment mask and tubing is supposed to be stored inside a clean respiratory set up bag and labeled with date of first use to determine when it needs to be changed with a new set. IPN also stated it is important to change the breathing treatment mask, tubing and respiratory set up bag every seven days to prevent respiratory infection and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During a record review of the facility's policy and procedure titled, Nebulizer (small volume), revised 1/14/2026, the policy indicated the purpose of this procedure is to safely and effectively use aerosol devices to deliver drugs rapidly and directly into the residents' airway. The policy also indicated placing the nebulizer back into the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's set-up bag and leaving the equipment at the bedside for further treatment, and it will be changed every seven days and as needed.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 12 of 22 resident's rooms (Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17 and 18) met the requirements of 80 square feet (sq. ft) for each resident in multiple resident bedrooms. This deficient practice had the potential to affect the residents' personal space, decrease freedom of mobility and could compromise the provision of care.Findings:During multiple observations of resident's rooms from 3/9/2026 to 3/12/2026, Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18 did not meet the minimum requirement of 80 sq. ft. per resident in multiple residents' rooms. During an observation on 3/9/2026 at 9:30 AM in room [ROOM NUMBER], Resident 29 was observed wheeling (moving around using the wheelchair) himself out of the resident's room safely. During an interview on 3/9/2026 at 10 AM in room [ROOM NUMBER], Resident 55 stated she has enough space in her room for herself and her belongings. During an interview with Resident 29 on 3/9/2026 at 12:30 PM, Resident 29 stated he has enough space in his room for himself and his belongings. During a review of the facility's Client Accommodation Analysis Form, dated 3/9/2026, the form indicated the facility had several rooms that measured less than the required 80 square footages per resident in multiple bedrooms. Ther following resident bedrooms were:room [ROOM NUMBER] (3 beds) and measured 222 sq. ft., to equal 74 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 194 sq. ft. to equal 64.6 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 212 sq. ft. to equal 70.6 sq. ft. per resident.room [ROOM NUMBER] (2 beds) and measured 148 sq. ft. to equal 74 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 227 sq. ft. to equal .6 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 209 sq. ft. to equal 69.6 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 227 sq. ft. to equal 75.6 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 211 sq. ft. to equal 70.3 sq. ft. per resident.room [ROOM NUMBER] (3 beds) and measured 221 sq. ft. to equal 73.6 sq. ft. per resident. room [ROOM NUMBER] (3 beds) and measured 221 sq. ft. to equal 73.6 sq. ft. per resident. room [ROOM NUMBER] (3 beds) and measured 230 sq. ft. to equal 76.6 sq. ft. per resident. room [ROOM NUMBER] (4 beds) and measured 293 sq. ft. to equal 73.25 sq. ft. per resident. During an observation of the facility and residents' room from 3/9/2026 to 3/12/2026, the residents residing in the rooms (Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18) with an application for room variance (an authorized exemption or deviation from standard facility regulations regarding room design, size, or occupancy. It is a formally granted approval that allows a facility to operate with non-standard accommodation, such as rooms that are smaller than required or have specialized layouts, provided the resident's care and safety are not compromised) were observed to have enough space to move freely inside the rooms. Each resident inside the affected rooms had beds and side tables with drawers. There was an adequate room for the operation and use of wheelchairs, walkers, canes or Hoyer lift (a mechanical device that helps move people between beds, chairs, or other places). The room variance did not affect the care and services provided to the residents when nursing staff were observed providing care to these residents. The Department is recommending approval of the room waiver request for 12 of 22 rooms (Rooms 3, 4, 5, 6, 7, 8, 11, 14, 15, 16, 17, and 18).