STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555578	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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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 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 for three of 19 (Resident 12, 1, and 79) sampled residents when the facility failed to: a. Develop and implement a care plan addressing Resident 12's visual impairment. b. Develop and implement a care plan for Resident 1 to address the risks associated with the use of Seroquel (a medication used to treat certain mental/mood disorders) which carries a Black Box Warning (is the most stringent safety warning the FDA can require from a drug manufacturer. As the name implies, a box warning is a bold, black-bordered notice at the top of aˆdrug'sˆlabel or informational package insert. This prominent warning is designed to alert health care providers and patients to serious, life-threatening, or permanently disabling risks associated with theˆdrug'sˆuse, should an adverse reaction occur). c. Develop and implement a care plan addressing Resident 79's hyperglycemiaˆ(occurs when a resident has too much sugar [glucose] in their blood, often because their body has too little insulin or cannot use it properly) which can lead to diabetes complications, such as nerve damage, eye disease and kidney damage.ˆ These deficient practices had the potential to negatively affect the provision of care and services provided to Resident 12, Resident 1, and Resident 79. Findings: a. During review of Resident 12's admission Record (AR), the AR indicated that the facility admitted the resident on 4/14/2026 with diagnoses that included essential hypertension (high blood pressure) and blindness right eye category 3 and left eye category 3 (Category 3 blindness is a World Health Organization (WHO) classification for moderate-to-severe visual impairment). During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 4/18/2026, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and the resident was totally dependent (helper does all the effort) on staff with eating, oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear. The resident`s MDS Section V (Section V of the Minimum Data Set (MDS) is the Care Area Assessment (CAA) Summary. It translates clinical data into actionable care planning by summarizing triggers, identifying resident problems, and documenting the interdisciplinary team's decisions on whether to proceed with further assessment) indicated that care planning for visual impairment is triggered. During a concurrent interview on 05/20/2026 at 9:41 a.m., with Registered Nurse 2 (RN 2), reviewed Resident 12`s MDS Section V and care plans. RN 2 stated that care planning for visual impairment was triggered in the CAA, however there was no care plan developed as it was missed by the MDS nurse. RN 2 stated that due to Resident 12`s impaired vision and diminished functional ability, there should have been a care plan with individualized interventions to promote safety and address the (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's needs During a review of the facility's policy and procedure (PP) titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/28/2026, the PP indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial and functional needs is developed and implemented for each resident.the interdisciplinary team (a group of health care professionals such as nursing, physician, and social services who meet to collaborate on the best plan of care for the resident) reviews and updates the care plan: at least quarterly, in conjunction with the required quarterly MDS assessment. b. During review of Resident 1's admission Record (AR), the AR indicated that the facility originally admitted the resident on 1/21/2024 and readmitted on [DATE] with diagnoses that included unspecified psychosis not due to a substance or known physiological condition (mental disorder, not otherwise specified) and Alzheimer`s disease (a progressive, irreversible brain disorder that slowly destroys memory and cognitive skills). During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and the resident required supervision or touching assistance (helper provides visual cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with eating, oral hygiene, toileting hygiene, shower, lower body dressing, putting on/taking off footwear. During a concurrent interview and record review on 5/20/2026 at 10:17 a.m., with Registered Nurse 2 (RN 2) reviewed Resident 12`s care plan and Seroquel's Black Box Warning details from the electronic health record (EHR). RN 2 stated that there was no care plan addressing the black box warning for Seroquel. RN 2 stated that medications with Black Box Warning should have a specific monitoring of the potential adverse effects of the medication (Seroquel) including suicidal ideation to ensure proper interventions are in place to promote resident safety. During a review of the facility provided Black Box Warning Details (printed from facility electronic health record on 5/20/2026 at 10:47 a.m.), which indicated that in patients of all ages who are started on antidepressant therapy, monitor closely for clinical worsening and for emergence of suicidal thoughts and behaviors. During a review of the facility's policy and procedure (PP) titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/28/2026, the P&P indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial and functional needs is developed and implemented for each resident.the interdisciplinary team (a group of health care professionals such as nursing, physician, and social services who meet to collaborate on the best plan of care for the resident) reviews and updates the care plan: at least quarterly, in conjunction with the required quarterly MDS assessment. c. During a review of Residentˆ79's admission Record, the admission Record indicated the facility originally admitted Residentˆ79ˆonˆ3/29/2026ˆwith diagnoses includingˆˆtype II diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing)ˆwith DM neuropathy(nerve damage caused by high blood sugar),andˆunspecifiedˆatrial fibrillationˆ(A-fibˆ-irregular and often rapid heartbeat).ˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Residentˆ79's MDS, the MDS indicated Residentˆ79'sˆwas severelyˆimpaired.ˆˆˆ During a review of Resident 79's Order Summary Report active as of 5/1/2026, the Order Summary Report indicated the following order dated 3/26/2026: ˆ-Accuchecksˆ(blood glucoseˆ[simple sugar] monitoringˆtests to measure blood sugar levels)ˆBID (two times a day)ˆfor diabetesˆand toˆcallˆtheˆmedical doctor if greater thanˆ(>) 200 milligrams per deciliter ([mg]/dL, a metric unit of measure for blood sugars). During a record review of Resident 79's electronic Medication Administration Record (eMAR) for 5/2026, the eMAR indicated that on 5/9/2026 the resident's blood glucose level was 302 mg/dL. During a concurrent interview and record review onˆ5/21/2026 at 9:26 a.m. with the Director of Nursing (DON), Resident 79's care plans were reviewed. The DONˆstatedˆResident 79 did not have a care plan that addressed hyperglycemia and included appropriate interventions. ˆThe DONˆstatedˆa care plan should have been developed to ensure the residentˆreceivedˆappropriate care, as uncontrolled hyperglycemia can lead to complicationsˆsuch asˆvomiting confusion,ˆnausea,ˆandˆdizziness.ˆˆ During a review ofˆthe facility's P&P titled,ˆCare Plans, Comprehensive Person-Centered,ˆreviewedˆonˆ1/28/2026,ˆthe P&Pˆindicatedˆaˆcomprehensive, 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.ˆThe 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.ˆThe comprehensive, person-centered care plan: includes measurable objectives and timeframes, describes the services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being, including: services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment.ˆ

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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: 1. Ensure the kitchen's ice machine was free from a black particle on the inside of the ice machine which had the potential to affect 87 of 88 residents receiving ice from the kitchen's ice machines. 2. Ensure three cutting boards were free from cracks and scratches. 3. Ensure two oven mitts did not have black spots on them. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins).Findings: During a kitchen observation and interview with Dietary Supervisor (DS), on 5/18/2026 at 9 a.m., observed the kitchen ice machine with black particles on the napkin that was used to wipe the interior sides and metal portion in the middle interior of the ice machine. The DS stated the black particles should not be there but be clean so that bacteria will not be present and had the potential for residents to get an infection. The DS stated she was not sure why they were there. The DS stated the ice machine is cleaned once a month by the Maintenance Director (MD). Observed the ice machine scoop with dark spots. The DS stated this should be discarded and replaced. Observed two green and one brown cutting board that had cracks and scratches with the DS. The DS stated those cutting boards should be discarded and replaced with new ones. Observed a pair of oven mitts that had dark spots on them. [NAME] 1 stated when the mitts are too much dirty, she discards them. The DS stated she was going to replace them. During an interview with the MD and DS upon return to the kitchen on 5/18/2026 at 10:02 a.m., the DS stated the ice machine is used for placing ice in bins to keep milk and juice cold for the residents. The MD and DS stated the ice machine was used that morning for that reason. The DS stated some residents ask for ice at times, but no one asked for ice this morning. The MD stated the ice machine was last cleaned approximately two weeks ago, displaying the Ice Machine Monthly Cleaning Log which indicated the MD cleaned the ice machine on 4/29/2026. The MD stated the dark spots may be from the breakdown of the coating on the ice machine scoop because staff hit the metal sides and middle metal part with the scoop. The MD displayed the ice scooper which was silver with dark spots. The MD stated the dark spots are from tarnish in which the coating that was on the ice scoop has come off. ˆThe MD stated it is important to clean the ice machine because it reduces possible contamination of ice to residents, prevents biofilm (a complex community of microorganisms, like bacteria, fungi, or algae that irreversibly stick to a surface) buildup, like sludge (another word for biofilm) buildup. The MD stated that biofilm is bacteria, that if not cleaned, had the potential to spread to residents. During a review of the facility's policy and procedure titled, Ice Machine Cleaning Procedures, last reviewed 1/28/2026, the policy indicated the ice machine needs to be cleaned and sanitized monthly. The policy indicated the internal components are to be cleaned monthly or per manufacturer's recommendations. During a review of the facility's policy and procedure titled, Safety and Infection Control, last reviewed 1/28/2026, the policy indicated the kitchen will be equipped with safe equipment, which is to be maintained in good working order.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review,ˆthe facilityˆfailed to notify the physicianˆfor two of 19 sampled residents (Resident 79 and Resident 41) when:1. Resident 79's blood sugar wasˆgreater thanˆ200ˆmilligrams per deciliter (mg/dL, a unit of measure for blood sugars, normal reference range 80 - 130 mg/dL)ˆasˆindicatedˆin the physician's order.ˆˆˆ ˆThis deficient practice placed Resident 79 at risk of becoming hyperglycemic (occurs when a resident has too much sugar [glucose] in their blood, often because their body has too little insulin or cannot use it properly) which can lead to diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) complications, such as nerve damage, eye disease and kidney damage. 2. Resident 41 refused Metformin (blood sugar lowering medication), Divalproex Sodium (medication to control seizure [sudden, uncontrolled burst of electrical activity in the brain, causing temporary changes in behavior, awareness, movements, or sensation]), and Clopidogrel Bisulfate (medication to prevent stroke]).This failure in lack of timely notification had the potential to result in improper medication timing and increased risk for adverse drug effects. Findings:ˆ 1. During a review of Resident 79's admission Record, the admission Record indicated the facility originally admitted Resident 79 on 3/29/2026 with diagnoses including type II diabetes mellitus with DM neuropathy (nerve damage caused by high blood sugar), andˆunspecified atrial fibrillation (A-fib -irregular and often rapid heartbeat). During a review of Residentˆ79's Minimum Data Set (MDSˆ-ˆa resident assessment tool), datedˆ3/25/2026, the MDS indicated Residentˆ79ˆcognitionˆ(the mental process of acquiring knowledge and understanding through thought, experience, and the senses) is severely impaired.ˆˆ During a review of Resident 79's Order Summary Report active as of 5/1/2026, the Order Summary Report indicated the following order dated 3/26/2026: ˆ-Accu-Checksˆ(blood glucoseˆ[simple sugar] monitoringˆtests to measure blood sugar levels)ˆBID (two times a day)ˆfor diabetesˆand toˆcallˆtheˆmedical doctor if greater thanˆ(>) 200 milligrams per deciliter ([mg]/dL, a metric unit of measure for blood sugars). During a record review of Resident 79's electronic Medication Administration Record (eMAR) for 5/2026, the eMAR indicated that on 5/9/2026 the resident's blood glucose level was 302 mg/dL. During a concurrent interview and record review on 5/20/2026 at 3:03 p.m. with Registered Nurse 1 (RN 1), Resident 79's physician orders and Medication Administration Record (MAR) for May 2026 were reviewed. RN 1 stated Resident 79's blood sugar was 302 mg/dL on 5/9/2026. RN 1 stated that based on the physician's order, the licensed nurse should have notified the physician when Resident 79's blood sugar exceeded 200 mg/dL. RN 1 stated it was important to follow the physician's orders to reduce Resident 79's risk of complications related to elevated blood sugar. RN 1 stated the high blood sugar result from 5/9/2026 should have been reported to the physician. RN 1 stated that failure to follow the physician's order could have resulted in Resident 79 experiencing increased thirst, headaches, blurred vision, and diabetic ketoacidosis (DKA). During a concurrent interview and record review on 5/21/2026 at 9:31 a.m. with the Director of Nursing (DON), Resident 79's physician orders and Medication Administration Record (MAR) for May 2026 were reviewed. The DON stated that the physician's order for accucheks required licensed nurses to notify the physician if the resident's blood sugar was greater than 200 mg/dL. The DON stated there were no progress notes or documentation indicating the physician had been notified regarding the elevated blood sugar result of 302 mg/dL on 5/9/2026. The DON stated that the failure to report the high blood sugar level to the physician placed Resident 79 at increased risk for complications associated with uncontrolled hyperglycemia, which could lead to conditions such as blurred vision, vomiting, confusion, nausea, and dizziness During a review of ˆthe facility's policy and procedure (P&P) titled, Nursing Care of the Older Adult with Diabetes Mellitus,ˆreviewedˆonˆ1/28/2026,ˆthe P&PˆindicatedˆBlood glucose monitoring: Follow the provider orders for blood glucose monitoring. Hyperglycemia. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Uncontrolled diabetes from lack of insulin or inadequate insulin results in hyperglycemia (blood sugar above target levels). Signs and symptoms of hyperglycemia may include the following: a. Increased thirst; b.Frequent urination; c.Sugar in the urine; d.Fatigue; e.Headache; and f.Blurred vision. Hyperglycemia and vascular damage can lead to: a.cardiovascular and cerebrovascular disease, including heart disease and stroke; b.cognitive impairment; c.kidney disease; d. glaucoma, cataracts, retinopathy, blindness; e.nerve damage (diabetic neuropathy); f.foot complications- neuropathy, dry skin, calluses, poor circulation, ulcers; g.skin problems - fungal/bacterial infections, itching, diabetic dermopathy; and/or h.gastroparesis (delayed stomach emptying). 2. During a review of^Resident^41's^admission Record, the^admission Record^indicated the facility admitted Resident 41 on^8/15/2022 and readmitted on [DATE]^with diagnoses including^epilepsy (brain disorder characterized by recurrent seizures [sudden, uncontrolled burst of electrical activity in the brain, causing temporary changes in behavior, awareness, movements, or sensation]),^type II diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with DM polyneuropathy(nerve damage caused by high blood sugar),and ^hypertension (HTN, high^blood pressure).^ During a review of Resident^41's MDS, dated [DATE], the MDS indicated Resident^41's^cognition was intact. During a review of Resident 41's Physician Order Summary Report, the report indicated the following orders: 1. Metformin (blood sugar lowering medication) tablet 1000 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) give 1000 mg orally two times a day for DM, dated 7/30/2024. 2. Divalproex Sodium (medication to control seizure) table 500 mg give 1 tablet by mouth two times a day for seizure, dated 7/30/2024. 3. Clopidogrel Bisulfate (medication to prevent [NAME]) 75 mg give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-commonly called a stroke) prophylaxis (PP-preventive care), dated 5/5/2026. During a review of Resident 41's Electronic Medication Administration Record (EMAR), the EMAR indicated that LVN 3 documented administration of the following medications as indicated by checkmarks and LVN 3's initials: 1. Metformin 1000 mg twice daily for Type 2 Diabetes Mellitus with diabetic polyneuropathy, scheduled for administration at 8 a.m. on 5/18/2026. 2. Divalproex Sodium 500 mg twice daily for seizure, scheduled for administration at 9 a.m. on 5/18/2026. 3. Clopidogrel 75 mg once daily for CVA PP, scheduled for administration at 9 a.m. on 5/18/2026. During a concurrent observation and interview on 5/18/2026 at 12:46 p.m. with LVN 3, at nursing station 1, observed inside Medication Cart 1 first drawer, a medication cup containing three medications (an orange tablet, a white tablet, and a blue tablet). LVN 3 stated the three tablets in the medication cup belonged to Resident 41. LVN 3 identified 3 medications as Metformin 500 mg for the 8 a.m. dose, Clopidogrel 75 mg for the 9 a.m. dose, and Divalproex Sodium 500 mg for the 9 a.m., dose. LVN 3 stated Resident 41 was sleepy and refused all three medications, so she saved them (medications) in a medication cup to administer them later. During an interview on 5/18/2026 at 1:02 p.m., with LVN 3, LVN 3 stated medications must be administered within the one^hour window (8 a.m. dose by 9 a.m.; 9 a.m. dose by 10 a.m.). LVN 3 stated she signed Resident 41 eMAR indicating the medications were given even though she did not administer them (Metformin for 8 a.m., Clopidogrel for 9 a.m., Divalproex Sodium for 9 a.m.). LVN 3 stated she did not document that Resident 41 refused the medications and did not notify the physician of the medication refusal. LVN 3 stated she placed the medications in a cup inside the cart to give later. LVN 3 stated she was aware that these medications are clinically significant and that not administering them as ordered could put the resident at risk for seizures (Divalproex Sodium), stroke (Clopidogrel), and elevated blood sugar (Metformin). LVN 3 further stated that she did not know why she signed the medication as given when it had not been administered. During an interview on 5/18/2026 at 1:12 p.m., with Director of Nursing (DON), the DON stated that LVN^3 did not document Resident^41's medication refusal and could not provide any documentation showing the physician had been notified, even 3-4 hours after the refusal occurred. The DON stated medications must be administered within one hour of their prescribed time; therefore, the 8^a.m. dose should have been given no later than 9^a.m., and the 9^a.m. dose no later than (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10ˆa.m. The DON stated that when a resident refuses medication, the nurse must immediately discard the medication, document the refusal and the reason, and notify the physician. The DON stated that missing the Clopidogrel dose increases the resident's risk for a stroke, missing the Divalproex Sodium dose increases the resident's risk for seizures, and missing the Metformin may result in elevated blood sugar.During a review of the facility's Policy and Procedure titled, Medication Administration,ˆreviewed on 1/28/2026,ˆthe 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 one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 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 ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed. During a review of the facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment,ˆreviewed on 1/28/2026,ˆthe P&P indicated documentation pertaining to a resident's request, discontinuation or refusal of treatment includes at least the following: the resident's response and stated reason(s) for request, discontinuation or refusal; the resident's condition and any adverse effects due to the request; the date and time the practitioner was notified as well as the practitioner's response.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to maintain privacy of confidential information for one of four sampled residents (Resident 2), when Licensed Vocational Nurse 1 (LVN 1) left the resident's electronic health record (EHR- a digital version of a patient's paper chart) open and unattended. This deficient practice violated Resident 2's right to privacy and confidentiality of medical records. Findings: During a review of Resident 2's admission Record, the admission Record indicated that the facility admitted Resident 2 on 2/23/2024 with diagnoses including dysphagia (difficulty swallowing) and essential hypertension (a condition in which blood pressure is higher than normal). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 4/29/2026, the MDS indicated that the resident had severely impaired cognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses). The MDS further indicated that Resident 2 was totally dependent (helper does all the effort) on staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on and taking off footwear and personal hygiene. During a concurrent medication pass observation and interview on 5/20/2026 at 7:44 a.m., observed Licensed Vocational Nurse 1 (LVN 1) stepped away from the medication cart located in the hallway and left the laptop computer screen open on top of the medication cart. The computer screen displayed Resident 2's medication information and was visible while unattended. During the interview, LVN 1 stated that he should have ensured that Resident 2`s electronic health record was not accessible and open while he stepped away from the medication cart. LVN 1 stated that it is a violation of the Health Insurance Portability and Accountability Act (HIPAA) to have the resident's health information visible to unauthorized persons. During a review of The Health Insurance Portability and Accountability Act (HIPAA) of 1996, it indicated the HIPAA Security Rule protects specific information cover the Privacy Rule law applies fully to nursing homes,ˆrequiring them to protect the privacy of residents' health information (PHI) by implementing appropriate safeguards, including technical, administrative, and physical measures to prevent unauthorized access, use, or disclosure of this information, particularly electronic protected health information (ePHI).ˆ During a review of the facility's policy and procedure (P&P), titled, Confidentiality of Information and Personal Privacy, last reviewed on 1/28/2026, the policy indicated that the facility will safeguard resident the personal privacy and confidentiality of all resident personal and medical records.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to update and revise a resident`s care plan by failing to: a. Update and revise a care plan after a resident's physician discontinued the resident's dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) treatment for one of one resident (Resident 83) reviewed under the dialysis care area. This deficient practice had the potential to result in Resident 83's inadequate care and monitoring due to the care plan not reflecting the resident's current dialysis treatment and related care needs. b. Update and revise a resident`s Activities of Daily Living (the fundamental self-care tasks required to manage one's physical well-being and live independently) care plan after the target date of 4/10/2026 for one of five residents (Resident 19) reviewed under the dementia care area. This deficient practice had the potential to result in care interventions that may not have reflected the resident's current needs and goals.Findings: a. During a review of Resident 83's admission Record (or Facesheet, the front page of the chart that contains a summary of basic information about the resident), the admission record indicated the facility admitted the resident to the facility on 9/15/2025 with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 83' s Quarterly (assessed every three months, includes the assessment period 12/16/2025 to 3/16/2026) Minimum Data Set (MDS, a resident assessment tool), dated 3/16/2026, the MDS indicated Resident 83 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 83 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. The MDS indicated Resident 16 received dialysis treatments. During a review of Resident 83's Physician's Orders, the orders indicated the following: Dialysis Appointment, Tuesday chair time (the time the resident is at the dialysis center receiving dialysis) 12 p.m. to 3:30 pm, in the afternoon every Tuesday for ESRD, dated 9/15/2026. Dialysis Site –Perma catheter (a specialized, durable tube inserted under the skin and into a large central vein to provide long-term access to the bloodstream) on right upper chest every shift for ESRD, dated 9/15/2026. Not anymore dialysis as per Resident 83's dialysis center, dated 1/27/2026. During a review of Resident 83's active Care Plan for Permacath, initiated 9/16/2025, the care plan indicated resident will not experience an infection at catheter site. During a review of Resident 83's active care plan for Dialysis, initiated 12/17/2025, the care plan indicated a goal that the resident will have no signs or symptoms of complications that could arise daily by the next three months. During a concurrent interview and record review with Registered Nurse 2 (RN 2) on 5/21/2026 at 9:52 a.m., reviewed Resident 83's Physician's Orders. RN 2 stated Resident 83's dialysis was discontinued (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 1/27/2026 per physician order. Reviewed care plans for Permacath and Dialysis with RN 2. RN 2 stated that these care plans should have been discontinued immediately because the resident is no longer receiving dialysis treatments. RN 2 stated this is important to ensure Resident 83 is receiving the appropriate care. During a concurrent interview and record review with the Director of Nursing (DON) on 5/21/2026 at 12:43 p.m., the DON reviewed Resident 83's Physician's Orders and care plans for Permacath and Dialysis. The DON stated Resident 83's dialysis treatments were discontinued on 1/27/2026. The DON stated the dialysis care plans should have been discontinued immediately because the resident no longer receives dialysis treatments and there was a positive change of condition for Resident 83 after 1/27/2026. The DON stated this is to ensure Resident 83's data is accurate and to provide the appropriate care for the Resident 83. ˆDuring a review of the facility's policy and procedure (PP) titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/28/2026, indicated the following: -Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. -The interdisciplinary team (a group of health care professionals such as nursing, physician, and social services who meet to collaborate on the best plan of care for the resident) reviews and updates the care plan: (but not limited to) when there is a significant change in the resident's condition. b. During a review of Resident 19's admission Record, the admission Record indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included unspecified dementia (a progressive state of decline in mental abilities) and chronic obstructive pulmonary disease (COPD, a progressive, irreversible lung disease that restricts airflow and makes breathing difficult). During a review of Resident 19' s Quarterly MDS, dated [DATE], the MDS indicated Resident 19 was cognitively intact with skills required for daily decision making. The MDS indicated Resident 19 required supervision or touching assistance (helper provides visual cues) with eating oral hygiene, toileting hygiene, lower body dressing, and putting on/and taking off footwear. During a concurrent record review and interview on 5/19/2026 at 2:45 p.m., reviewed with Registered Nurse 2 (RN 2) Resident 19`s Care Plan for ADL deficit related to anxiety, depression, schizophrenia (a mental health disorder that affects how a person thinks, feels, and behaves), dementia and COPD. The review indicated that the CP for ADL deficit was initiated on 1/09/2026 with a goal /target date of 4/10/2026. The review of the CP for ADL deficit was not revised or renewed after the 4/10/2026 target date. RN 2 stated the care plans are evaluated quarterly to determine whether the goals have been met and whether the interventions remain effective to ensure continuity of care. RN 2 stated that without an updated care plan, staff may be unable to determine whether the resident is progressing toward goals or experiencing decline in condition, and necessary services may not be provided. During a review of the facility's PP titled, Care Plans, Comprehensive Person-Centered, last reviewed 1/28/2026, the PP indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident`s physical, psychosocial and functional (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needs is developed and implemented for each resident.the interdisciplinary team reviews and updates the care plan: at least quarterly, in conjunction with the required quarterly MDS assessment.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed toˆprovide books of interest to a resident to support the resident's activity preferences as identified in the Minimum Data Set (MDS - a standardized assessment and care screening tool) dated 9/7/2025, for one of three residents (Resident 82) investigated under the care area of Activities. This deficient practice had the potential to result in the resident's activity preferences not being honored, leading to reduced quality of life.Findings:ˆ During a review of Resident 82's admission Record, the admission Record indicated that the facility admitted the resident to the facility on 9/03/2025 and re-admitted on [DATE], with diagnoses that included but not limited to depression and schizophrenia (a chronic and severe brain disorder that affects how a person interprets reality). During a review of Resident 82`s admission Minimum Data Set (MDS - a resident assessment tool), dated 9/07/2025, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS Interview for Activity Preferences indicated that it was very important to the resident to have books, newspapers, and magazines to read. During a concurrent observation and interview with Resident 82 onˆ5/18/2026 at 10:24ˆa.m.,ˆobservedˆresidentˆin his room.ˆThe residentˆstatedˆhe spends most of his time in his room reading books. The resident stated that he had already read the book at his bedside twice and did not have any other books available. The resident further stated that he would be glad if staff could provide or lend him additional books and National Geographic magazines to read. During a follow up observation and interview with Resident 82 in his room on 5/19/2026 at 4:05 p.m., in the presence of the Activity Director (AD), observed Resident 82 watching television. Resident 82 stated that he only has one book which he had already read twice. Resident 82 stated that he would love to have additional books and National Geographic magazines to read. During an interview on 5/19/2026 at 4:10 p.m. with the AD, the AD stated residents who do not attend activities should still be provided with activities of their preference. The AD stated that if a resident prefers reading, the facility should provide reading materials consistent with the resident's interests. The AD further stated that it would be frustrating for the residents if they did not have access to books of if their activity preferences are not supported. During a review of the facility`s policy and procedure (P&P) titled Group Programs and Activities Calendar, last reviewed on 1/28/2026, the P&P indicated that the activity director/coordinator periodically reviews the current types of activity programs in terms of the current facility population and changes are made based on this analysis with input from the resident council and the interdisciplinary team.ˆˆ

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 to meet the needs of residents during review of one of two medication carts (Med Cart 1) affecting Resident 41 by failing to: 1. Ensure Licensed Vocational Nurse 3 (LVN) 3 administer medications within the required oneˆhour timeframe. 2. Ensure LVN 3 did not document medications in the electronic Medication Administration Record (eMAR) as administered when medications have not been given. 3. Ensure LVN 3 document medication refusal in the eMAR and notify the physician of the refusal. 4. Ensure LVN 3 store medications in the medication cart in accordance with the facility policy. These failures placed the resident at risk for avoidable harm and significant clinical complications due to improper medication administration, documentation, and storage practices. Findings: During a review ofˆResidentˆ41'sˆadmission Record, theˆadmission Recordˆindicated the facility admitted Resident 41 onˆ8/15/2022 and readmitted on [DATE]ˆwith diagnoses includingˆepilepsy (brain disorder characterized by recurrent seizures(sudden, uncontrolled burst of electrical activity in the brain, causing temporary changes in behavior, awareness, movements, or sensation),ˆtype II diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with DM polyneuropathy(nerve damage caused by high blood sugar),and ˆhypertension (HTN, highˆblood pressure).ˆ During a review of Residentˆ41's Minimum Data Set (MDS - a resident assessment tool), dated 4/29/2026, the MDS indicated Residentˆ41'sˆcognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses) was intact. During a review of Resident 41's Physician Order Summary Report, the report indicated the following orders: 1. Metformin (blood sugar lowering medication) tablet 1000 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) give 1000 mg orally two times a day for DM, dated 7/30/2024. 2. Divalproex Sodium (medication to control seizure) table 500 mg give 1 tablet by mouth two times a day for seizure, dated 7/30/2024. 3. Clopidogrel Bisulfate (medication to prevent [NAME]) 75 mg give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-commonly called a stroke Prophylaxis (PP), dated 5/5/2026. During a review of Resident 41's Electronic Medication Administration Record (EMAR), the EMAR indicated that LVN 3 documented administration of the following medications as indicated by checkmarks and LVN 3's initials: 1. Metformin 1000 mg twice daily for Type 2 Diabetes Mellitus with diabetic polyneuropathy, scheduled for administration at 8 a.m. on 5/18/2026. 2. Divalproex Sodium 500 mg twice daily for seizure, scheduled for administration at 9 a.m. on 5/18/2026. 3. Clopidogrel 75 mg once daily for CVA PP, scheduled for administration at 9 a.m. on 5/18/2026. During a concurrent observation and interview on 5/18/2026 at 12:46 p.m. with LVN 3, at nursing station 1, observed inside Medication Cart 1 first drawer, a medication cup containing three medications (an orange tablet, a white tablet, and a blue tablet). LVN 3 stated the three tablets in the medication cup belonged to Resident 41. LVN 3 identified 3 medications as Metformin 500 mg for the 8 a.m. dose, Clopidogrel 75 mg for the 9 a.m. dose, and Divalproex Sodium 500 mg for the 9 a.m., dose. LVN 3 stated Resident 41 was sleepy and refused all three medications, so she saved them (medications) in a medication cup to administer them later. During a concurrent interview and record review on 5/18/2026 at 12:58 p.m. with LVN 3, reviewed Resident 41's eMAR from 5/1/2026 to 5/30/2026. LVN 3 stated the eMAR indicated the following medications had been administered on 5/18/2026: 1. Metformin 1000 mg twice daily for Type 2 Diabetes Mellitus with diabetic polyneuropathy for the 8 a.m. dose 2. Divalproex Sodium 500 mg twice daily for seizure for the 9 a.m. dose.3. Clopidogrel 75 mg once daily for CVA PP for the 9 a.m. dose.During an interview on 5/18/2026 at 1:02 p.m., with LVN 3, LVN 3 stated medications must be administered within the oneˆhour window (8 a.m. dose by 9 a.m.; 9 a.m. dose by 10 a.m.). LVN 3 stated she signed Resident 41 eMAR indicating the medications were given even though she did not (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administer them (Metformin for 8 a.m., Clopidogrel for 9 a.m., Divalproex Sodium for 9 a.m.). LVN 3 stated she did not document that Resident 41 refused the medications and did not notify the physician of the medication refusal. LVN 3 stated she placed the medications in a cup inside the cart to give later. LVN 3 stated she was aware that these medications are clinically significant and that not administering them as ordered could put the resident at risk for seizures (Divalproex Sodium), stroke (Clopidogrel), and elevated blood sugar (Metformin). LVN 3 further stated that she did not know why she signed the medication as given when it had not been administered. During an interview on 5/18/2026 at 1:12 p.m., with Director of Nursing (DON), the DON stated that LVNˆ3 did not document Residentˆ41's medication refusal and could not provide any documentation showing the physician had been notified, even 3-4 hours after the refusal occurred. The DON stated medications must be administered within one hour of their prescribed time; therefore, the 8ˆa.m. dose should have been given no later than 9ˆa.m., and the 9ˆa.m. dose no later than 10ˆa.m. The DON stated that when a resident refuses medication, the nurse must immediately discard the medication, document the refusal and the reason, and notify the physician. The DON stated that missing the Clopidogrel dose increases the resident's risk for a stroke, missing the Divalproex Sodium dose increases the resident's risk for seizures, and missing the Metformin may result in elevated blood sugar. The DON stated that licensed nurses must never save refused medications in the cart, since they may be forgotten or mistakenly administered later, and stated that all three medications were clinically significant and that failure to administer them as ordered constituted a significant medication error. During an interview on 5/21/2026 at 1:28 p.m., with DON, the DON stated that medications should be initialed and checked mark only after each medication is administered. The DON stated if a resident refused the staff should document refusals by entering 2 in the eMAR and record the refusal in the progress notes at the time it occurs, not 3-4 hours later. During a review of the facility's Policy and Procedure titled, Medication Administration,ˆreviewed on 1/28/2026,ˆthe 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 one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 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 ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed. During a review of the facility's P&P titled, Medication Labeling and Storage,ˆreviewed on 1/28/2026,ˆthe P&P indicated Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications are assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. Medications may not be transferred between containers. During a review of the facility's P&P titled, Requesting, Refusing and/or Discontinuing Care or Treatment,ˆreviewed on 1/28/2026,ˆthe P&P indicated documentation pertaining to a resident's request, discontinuation or refusal of treatment includes at least the following: the resident's response and stated reason(s) for request, discontinuation or refusal; the resident's condition and any adverse effects due to the request; the date and time the practitioner was notified as well as the practitioner's response. During a review of the facility's P&P titled, Documentation,ˆreviewed on 1/28/2026,ˆthe 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 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Documentation .in the medical record will be objective (not opinionated or speculative), complete, and accurate. During a review of the facility's P&P titled, Adverse Consequences and Medication Errors,ˆreviewed on 1/28/2026,ˆthe P&P indicated, medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. Examples of medications errors include omission - a drug is ordered but not administered and, wrong time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of significant medication errors for one of one of resident (Resident 30) reviewed under the care area of insulin by failing to clarify and carry out the physician's order to change Resident 30's insulin administration regimen from twice daily to once daily, resulting in the resident not receiving prescribed insulin from 4/3/2026 through 5/20/2026. This deficient practice had the potential to result in uncontrolled blood glucose levels, including hyperglycemia and its associated complications such as nerve damage, kidney damage and diabetic ketoacidosis (DKA-life threatening medical emergency when people with diabetes do not have insulin. Without insulin, the body cannot use energy, so it breaks down fat too fast, creating a toxic amount of acid) due to the failure to administer prescribed insulin therapy.Findings: During a review of Resident 30 's admission Record, the admission Record indicated that the facility admitted Resident 30 on 3/30/2026 with diagnoses including essential hypertension (a condition in which blood pressure is higher than normal) and type 2 diabetes mellitus (a chronic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated 4/03/2026, the MDS indicated that the resident had the ability to make self-understood and had the ability to understand others). The MDS further indicated that Resident 30 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, shower, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent record review and interview on 5/21/2026 at 8:27 a.m., reviewed Resident 30`s physician`s telephone orders dated 4/3/2026 and Medication Administration Record (MAR) from 4/3/2026 to 5/20/2026, with the Director of Nursing (DON). The DON stated the order indicated to discontinue Lantus Insulin (a long-acting man-made-insulin used to control high blood sugar in adults and children with diabetes mellitus) twice a day and to only give Lantus Insulin in the morning, Accu-Chek (painless finger-pricking to draw blood samples for testing) twice a day and call physician if the blood sugar is greater than 200 milligram per deciliter (mg/dl- for individuals without diabetes, normal blood sugar levels generally range from 70 to 99 mg/dL when fasting, and stay below [140 mg/dL] two hours after a meal). The DON stated that the change in the physician's order was missed by the licensed nurses, resulting in the resident not receiving Lantus insulin from 4/3/2026 through 5/20/2026. The DON stated that because the order was not carried out, the medication was not reflected on the MAR. During a review of the MARs from 4/2026 through 05/2026, the DON confirmed there was no documented administration of Lantus insulin during that period. The DON stated that not receiving Lantus Insulin could have resulted in Resident 30 experiencing hyperglycemia with symptoms such as nausea, vomiting and dizziness. The DON stated that untreated hyperglycemia could have resulted in complications and hospitalization. During a review of the facility`s policy and procedure (P&P) titled Nursing Care of the Older Adult with Diabetes Mellitus,) last reviewed on 1/28/2026, the PP indicated that Complications associated with diabetes can be attributed to: uncontrolled hyperglycemia and subsequent damage to vasculature.hyperglycemia and vascular damage can lead to kidney disease, glaucoma, nerve damage. During a review of the facility's P&P titled, Adverse Consequences and Medication Errors,ˆdated 1/28/2026,ˆthe P&PˆindicatedˆA medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services.ˆExamples of medications errorsˆincludeˆomission - a drug is ordered but not administered and,ˆwrong time.ˆˆ

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure an expired Lantus Insulin (a long-acting man-made-insulinˆused to control high blood sugar in people with diabetes mellitus [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing]) pen for Resident 30 was removed from one of two medication carts (Med Cart 2) inspected during inspection of medication carts. This deficient practice had the potential for the Lantus Insulin to be used beyond the use by date which could affect the efficacy and render the insulin non-effective in the management of Resident 30's diabetes. Findings: During a concurrent medication cart inspection of Med Cart 2 and interview on [DATE] at 11:27 a.m., with Licensed Vocational Nurse 2 (LVN 2), observed stored inside Med Cart 2 a Lantus Insulin pen prescribed for Resident 30, with an open date of [DATE]. LVN 2 stated that the Lantus insulin pen should only be used for 28 days after opening. LVN 2 stated that if it used beyond 28 days, the medication may lose its effectiveness, which could result in uncontrolled blood sugar levels for the resident. During a review of Resident 30 's admission Record, the admission Record indicated that the facility admitted Resident 30 on [DATE] with diagnoses essential hypertension (a condition in which blood pressure is higher than normal) and type 2 diabetes mellitus (a chronic condition where the body either resists the effects of insulin or doesn't produce enough to maintain normal glucose levels). During a review of Resident 30's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated that the resident had the ability to make self-understood and had the ability to understand others). The MDS further indicated that Resident 30 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, shower, lower body dressing, putting on/taking off footwear and personal hygiene. During an interview on [DATE] at 3:19 p.m., interviewed Registered Nurse 1 (RN 1). RN 1 stated that expired medication should not be kept in the medication cart to prevent its potential use and if used it will no longer be effective which can result to Resident 30 experiencing hyperglycemia and its complications such as blurred vision and kidney disease. During a review of the facility`s policy and procedure (PP) titled Medication Storage and Labeling, the PP indicated that multi-dose vials that have been opened or accessed are (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain complete and accurate clinical records for two of 19 sampled residents (Resident 23 and Resident 41) by: a. Failing to accurately document insulin (a natural hormone [are chemicals which circulate in the blood stream] that turns food into energy and manages your blood sugar level) injection site administrations. The deficit practice resulted in incomplete and inaccurate clinical records that did not reflect the resident's actual treatment and failed to meet accepted documentation standards. b. Failing to ensure Licensed Vocational Nurse 3 (LVN 3) did not document medications in the electronic Medication Administration Record (eMAR) as administered when medications have not been given. The deficit practice resulted in inaccurate and incomplete medication documentation that did not reflect the resident's actual medication status. Findings: a. During a review of ^Resident^23's^admission Record, the^admission Record^indicated the facility admitted Resident 23 on^2/13/2024 and readmitted on [DATE]^with diagnoses including^type II diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) , hypertension (HTN, high^blood pressure), and bipolar disorder (a mental health condition characterized by significant and often severe mood swings that affect a person's energy, activity levels, and behavior). During a review of Resident^23's Minimum Data Set (MDS - a resident assessment tool), dated 5/04/2026, the MDS indicated Resident^23's^cognition ((the mental process of acquiring knowledge and understanding through thought, experience, and the senses). During a review of Resident 23's Electronic Medication Administration Record (eMAR) for the period 5/01/2026-5/31/2026, the eMAR indicated an order for Insulin Glargine (long-acting insulin to lower blood glucose level) 100 units/ml (units of a drug are present per milliliter), inject 38 units subcutaneously (under skin) at bedtime. The area designated for documenting the insulin injection site contained numerical entries instead of anatomical locations. The following entries were recorded: 5/07/2026 - 142 5/13/2026 - 212 5/14/2026 - 156 5/18/2026 - 189 5/19/2026 - 303 During a concurrent interview and record review on 5/20/2026 at 4:37 pm with Director of Nursing (DON), Resident 23's eMAR for the period of 5/01/2026 to 5/31/2026 was reviewed. The DON stated the eMAR indicated an active order for Insulin Glargine 100 units/mL, 38 units subcutaneously at bedtime. The DON stated that the area designated for documenting the insulin injection site is required to contain a specific anatomical location, such as right abdomen, left abdomen, right thigh, or left thigh. The DON confirmed that the entries documented on the following dates-142 (5/07/2026), 212 (5/13/2026), 156 (5/14/2026), 189 (5/18/2026), and 303 (5/19/2026)-were incorrect and not acceptable documentation. The DON stated these numbers do not correspond to any approved facility code, and nursing staff should not be documenting numerical values in place of anatomical locations. The DON acknowledged that the entries were inaccurate, did not reflect proper documentation standards, and were not consistent with facility policy for insulin administration recording. The DON stated that the purpose of documenting the injection site is to ensure proper rotation of sites. 2. During a review of ^Resident^41's^admission Record, the^admission Record^indicated the facility admitted Resident 41 on^8/15/2022 and readmitted on [DATE]^with diagnoses including^epilepsy (brain disorder characterized by recurrent seizures (sudden, uncontrolled burst of electrical activity in the brain, causing temporary changes in behavior, awareness, movements, or sensation),^type II diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) with DM polyneuropathy(nerve damage caused by high blood sugar), and ^hypertension (HTN, high^blood pressure).^ During a review of Resident^41's MDS, dated [DATE], the MDS indicated Resident^41's^cognition was intact.During a review of Resident 41's Electronic Medication Administration Record (EMAR), the EMAR indicated that LVN 3 documented administration of the following medications as indicated by checkmarks and LVN 3's initials: 1. Metformin 1000 mg twice (continued on next page)

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	555578	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holiday Manor Care Center	20554 Roscoe Blvd Canoga Park, CA 91306

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daily for Type 2 Diabetes Mellitus with diabetic polyneuropathy, scheduled for administration at 8 a.m. on 5/18/2026. 2. Divalproex Sodium 500 mg twice daily for seizure, scheduled for administration at 9 a.m. on 5/18/2026. 3. Clopidogrel 75 mg once daily for cerebrovascular accident (CVA-commonly called a stroke) prophylaxis (PP- preventive care), scheduled for administration at 9 a.m. on 5/18/2026. During a concurrent observation and interview on 5/18/2026 at 12:46 p.m. with LVN 3, at nursing station 1, observed inside Medication Cart 1 first drawer, a medication cup containing three medications (an orange tablet, a white tablet, and a blue tablet). LVN 3 stated the three tablets in the medication cup belonged to Resident 41. LVN 3 identified 3 medications as Metformin 500 mg for the 8 a.m. dose, Clopidogrel 75 mg for the 9 a.m. dose, and Divalproex Sodium 500 mg for the 9 a.m., dose. LVN 3 stated Resident 41 was sleepy and refused all three medications, so she saved them (medications) in a medication cup to administer them later. During a concurrent interview and record review on 5/18/2026 at 12:58 p.m. with LVN 3, reviewed Resident 41's eMAR from 5/1/2026 to 5/30/2026. LVN 3 stated the eMAR indicated the following medications had been administered on 5/18/2026: 1. Metformin 1000 mg twice daily for Type 2 Diabetes Mellitus with diabetic polyneuropathy for the 8 a.m. dose 2. Divalproex Sodium 500 mg twice daily for seizure for the 9 a.m. dose.3. Clopidogrel 75 mg once daily for CVA PP for the 9 a.m. dose.During an interview on 5/18/2026 at 1:02 p.m., with LVN 3, LVN 3 stated medications must be administered within the oneˆhour window (8 a.m. dose by 9 a.m.; 9 a.m. dose by 10 a.m.). LVN 3 stated she signed Resident 41 eMAR indicating the medications were given even though she did not administer them (Metformin for 8 a.m., Clopidogrel for 9 a.m., Divalproex Sodium for 9 a.m.). LVN 3 further stated that she did not know why she signed the medication as given when it had not been administered. During an interview on 5/21/2026 at 1:28 p.m., with DON, the DON stated that medications should be initialed and checked mark only after each medication is administered.The DON stated if a resident refused the licensed nurse should document refusals by entering 2 in the eMAR and record the refusal in the progress notes at the time it occurred, not 3-4 hours later. During a review of the facility's Policy and Procedure titled, Medication Administration,ˆreviewed on 1/28/2026,ˆthe 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 one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 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 ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: any complaints or symptoms for which the drug was administered; any results achieved and when those results were observed.During a review of the facility's P&P titled, Documentation,ˆdated 1/28/2026,ˆthe 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. Documentation .in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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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 stewardship program (set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use) by failing to conduct infection surveillance for a resident who was prescribed a long-term (being prescribed for more than seven to ten days) antibiotic for one (Residents 4) of three residents sampled for antibiotic usage. This deficient practice had the potential for Resident 4 to develop antibiotic resistance from unnecessary or inappropriate antibiotic use for future infections. Findings: During a review of Resident 4's admission Record (face sheet, the front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 1/29/2021and re-admitted on [DATE] with diagnoses that included liver cirrhosis (condition where healthy liver tissue is permanently replaced by scar tissue due to chronic, long-term liver damage). During a review of Resident 4's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/27/2026, indicated Resident 4 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 4 was dependent (helper does all the effort; resident does not of the effort to complete the activity) on staff for showering, dressing, and personal hygiene. The MDS indicated Resident 4 is taking an antibiotic medication. During a review of Resident 4's Physician's Orders, dated 3/27/2026, the Physician's Orders indicated an order for Neomycin Sulfate Oral Tablet 500 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth three times a day for cirrhosis. During a review of Resident 4's Care Plan for Liver Cirrhosis, initiated 2/28/2026, the care plan indicated Resident 4 is at risk for discomfort, shortness of breath, fluid retention and exacerbation (a sudden worsening of a disease) secondary to liver cirrhosis. The care plan indicated a goal that Resident 4 will have no signs or symptoms of exacerbation manifested by shortness of breath and discomfort daily for 90 days. The care plan indicated an intervention to give Neomycin Sulfate 500 mg tablet by mouth three times a day as ordered. During a concurrent interview and record review with the Infection Preventionist (IP) on 5/20/2026 at 9:13 a.m., the IP reviewed Resident 4's Liver Cirrhosis Care Plan. The IP stated once a resident is prescribed an antibiotic, an infection surveillance form (a systematic collection of data to track infection which is collected when a resident has certain signs and symptoms that could be a bacterial infection) should be created to ensure the McGeer's (a criteria of signs and symptoms that must be met to qualify an infection as being a true infection) criteria and Loeb's criteria (to determine whether starting antibiotics is necessary for a suspected infection, thereby reducing antibiotic overuse) are met. The IP stated she documents on the infection surveillance form for new antibiotics within 48 hours admission to the facility and checks to see if a resident's signs and symptoms (s/s) follow McGeer's and Loeb's criteria and to communicate with the doctor if the s/s do not meet McGeer's or Loeb's criteria to see if he wants to continue the antibiotic. The IP stated Resident 4 is on the antibiotic, Neomycin, long term (longer than seven to ten days) to prevent bacterial growth and prevent accumulation of ammonia. When asked why this information was not included on Resident 4's care plan, the IP stated another licensed nurse wrote the care plan and may not have been as knowledgeable regarding Resident 4's condition. When asked why there was no infection surveillance form for Resident 4's Neomycin use, the IP stated Resident 4 was on the antibiotic long term. When asked if there should be some documentation such as a physician's note that indicates the rationale for the long-term use of Neomycin, the IP stated, upon further consideration, there should be some documentation somewhere regarding this. The IP stated the pharmacy is obtaining the rationale. The IP stated she would speak with Resident 4's physician to obtain documentation for his rationale for continued use of the Neomycin. The IP stated infection surveillance is important for Resident 4's well-being, to monitor (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood laboratory values such as ammonia, to have no adverse effects of the medication, and to ensure the physician and licensed nurses are on the same page regarding Resident 4's condition. During an interview with the Director of Nurses (DON) on 5/21/2026 at 12:50 p.m., the DON stated every resident prescribed an antibiotic should have a surveillance assessment. The DON stated this is important to monitor the usage of the antibiotic, monitor the effectiveness. The DON stated it is important to know why a resident is being treated and to ensure a resident is not at risk for more infection. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, last reviewed 1/28/2026, the P&P indicated the following: -The IP will be responsible for infection surveillance and multi-drug-resistant organism (MDRO, refers to bacteria that have mutated and are no longer killed by the antibiotics typically used to treat them) tracking. -The IP will collect and review data such as: i. Type of antibiotic ordered, route of administration, antibiotic costs ii. Whether the order was made by phone, if order was given by attending physician iii. ^ Whether appropriate tests such as cultures were obtained before ordering antibiotic iv. Whether the antibiotic was changed during the course of treatment During a review of the facility's P&P titled, Antibiotic Time-Out, last reviewed 1/28/2026, the P&P indicated the following: -An antibiotic time-out is meant to prompt the physician to revisit the need for the antibiotic 48-72 hours after starting the antibiotic. -The facility licensed nurse (IP, DON, or charge nurse) will contact the prescribing physician 48-72 hours after initiation of antibiotics to answer these questions: a. Does the resident have an infection that will respond to antibiotics? b. If so, is the resident on the right antibiotic (s) dose, and route of administration? c. Can a more targeted antibiotic be used to treat the infection? d. How long should the resident receive the antibiotic? ^