STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to honor the resident's right to a dignified existence for one of two sampled residents (Resident 22), reviewed for dignity care area by failing to prevent a confused resident from undressing and removing her top clothing and was vulnerable for visitors and staff's view when passing by the resident's bed. This deficient practice had the potential to cause emotional distress and affect their self-esteem and cause a loss of dignity and decline in psychosocial wellbeing. Findings: During a review of Resident 22's admission Record, the admission Record indicated the facility admitted the resident on 12/11/2024, with diagnoses including mood disorder (a mental health condition characterized by significant disturbances in a person's emotional state, leading to prolonged periods of extreme happiness, sadness, or both), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). During a review of Resident 22's History and Physical (H&P), dated 12/1/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 22's Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent on lower body dressing while needing partial to moderate assistance on upper body dressing. During a concurrent observation and interview on 6/30/2025, at 11:08 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 22's room, observed resident without a shirt on, upper body exposed and the curtain was not drawn. LVN 1 stated the resident tends to remove her clothing and she will help the resident put back her clothes on. During an interview on 6/30/2025, at 11:16 a.m., with Registered Nurse (RN) 2, RN 2 stated she was not aware of Resident 22 removing her clothes. RN 2 stated if she knew the resident was disrobing or removing her clothes, she would have assessed the resident and created a care plan on the disrobing behavior of the resident. During an interview on 6/30/2025, at 11:18 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 22 had been removing her clothes every time she was changed for two weeks now and he reported the resident's behavior to his charge nurse. CNA 3 stated he cannot remember anymore who he spoke to but he is sure he had communicated the issue to a licensed staff. CNA 3 stated to his knowledge every time they have a resident that undresses themselves and were confused, the licensed staff created a care plan on the disrobing behavior of the resident to promote resident respect and dignity. During an interview on 7/1/2025, at 2:47 p.m., with LVN 1, LVN 1 stated Resident 22 removing her upper clothing and leaving the curtains open is a dignity issue for the resident. LVN 1 stated putting herself in the shoes of the resident, she does not want anybody to see her topless even if she has impaired cognition, she would love her dignity to be promoted and respected by making sure she was distracted from the disrobing behavior and drawing the curtains to protect her dignity. LVN 1 stated every time they have a resident that disrobes and confused, they communicate them to all the healthcare team and monitor the resident for disrobing and making sure the curtains was drawn to provide privacy. LVN 1 stated the RN supervisors creates a care plan to standardize the care provided to the resident to promote dignity and respect to resident. During an interview on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON stated the facility failed to promote dignity to resident by failing to timely identify the behavior, distract the resident from disrobing by providing activities, and formulate a care plan and discuss with the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) members the resident's behavior of disrobing. The DON stated the licensed staff should have created and implemented a care plan on the resident's disrobing to ensure they identify the approaches applicable to the resident's behavior and communicate the issues to all healthcare team to promote dignity and respect on a demented (acting in a confused, irrational, or insane manner) resident. The DON stated the failure of the staff to identify the disrobing behavior placed the resident at risk for violation of their right to dignified existence. The DON stated that even if the resident had dementia (a progressive state of decline in mental abilities), they needed to be treated with dignity and respect as anybody else. During a review of the facility's recent policy and procedure (P&P) titled Dignity, last reviewed on 1/29/2025, the P&P indicated each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem e. encouraged to dress in clothing that they

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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. (continued on next page)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to honor the resident's right to be informed in advance by the physician or other practitioner or professional, of the risks and benefits of proposed care, treatment and treatment alternative or option for two of two sampled residents (Residents 25 and 1) reviewed for informed consents (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to ensure:1. Resident 25's Zyprexa (treatment for mental health conditions such as schizophrenia and bipolar I disorder) had the correct dosage on the consent form.2. Resident 1's Depakote (it helps manage manic or mixed episodes [periods of high energy, irritability, or both] in adults with bipolar disorder) indicated the dosage on the consent form. This deficient practice violated the residents' right to make an informed decision regarding the use of psychoactive medications (substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions).Findings: 1. During a review of Resident 25's admission Record, the admission Record indicated the facility admitted the resident on 5/5/2025, with diagnoses including depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 25's History and Physical (H&P), dated 5/6/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 25's Minimum Data Set (MDS, a resident assessment tool), dated 5/10/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in thinking skills that affects daily life). The MDS indicated the resident was on a high-risk drug class antipsychotic (medications used to treat psychosis, a mental state where a person's thoughts and perceptions are significantly distorted). During a review of Resident 25's Order Summary Report, dated 6/11/2025, the Order Summary Report indicated an order for Zyprexa oral tablet 5 milligrams (mg, a unit of weight) (Olanzapine). Give 1 tablet by mouth every 12 hours for schizoaffective disorder, bipolar (a mental health condition that causes extreme mood swings) type monitor behavior (m/b) paranoia (the irrational and persistent feeling that people are 'out to get you' or that you are the subject of persistent, intrusive attention by others), delusional (having false or unrealistic beliefs), responding to internal stimuli as evidence of talking to self, affecting activities of daily living. During a review of Resident 25's Care Plan (CP) Report regarding the resident's use of Zyprexa and having episodes of schizoaffective disorder, bipolar type, last revised on 6/23/2025, the CP indicated an intervention to explain all procedures and involve the family in care if possible/available and encourage resident to discuss interest/concerns. During a review of Resident 25's Informed Consent, dated 5/5/2025, the Informed Consent indicated a consent for Zyprexa 1 mg 1 tablet every (q) 12 hours (hrs.). During a concurrent interview and record review on 7/1/2025, at 9:10 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 reviewed Resident 25's Medical Diagnosis, Order Summary Report, Informed Consent, and Care Plan. LVN 3 stated the Zyprexa dosage written on the Informed Consent was wrong. LVN 3 stated instead of Zyprexa 5 mg per physician's order, the Informed Consent indicated 1 mg. LVN 3 stated it was important to indicate the correct dosage on the form as it might affect the decision of the resident or representative to accept or decline the proposed treatment. During a concurrent interview and record review on 7/1/2025, at 3:36 p.m., with Registered Nurse (RN) 3, RN 3 reviewed Resident 25's Medical Diagnosis, Order Summary Report, and Informed Consent. RN 3 stated the dosage on the use of Zyprexa Informed Consent was wrong, it should be 5mg per physician's order. RN 3 stated it was important to ensure the correct dosage on the Informed Consent is indicated as it could potentially affect the decision of the resident to accept or decline the proposed medication treatment. During a concurrent interview and record review on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON reviewed Resident 25's Informed Consent. The DON stated the dosage indicated on the Zyprexa Informed Consent was wrong, it should be 5mg. The DON stated it was important to indicate the correct dosage on the informed consent to ensure the resident or representative was accurately informed of the physician's proposed treatment to honor the resident's right to informed consent. During a review of the facility's recent policy and procedure (P&P) titled Policy: Informed Consent, last reviewed on 1/29/2025, the P&P indicated to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based an observation, interview, and record review, the facility failed to ensure that two of eight residents (Residents 21 and 79) who attended the Resident Council Meeting (gathering of residents, typically in a long-term care or public housing setting, where they discuss issues, concerns, and suggestions related to their living environment and quality of life) were aware of the availability and location of the facility's latest survey results.This failure had the potential for the residents and their legal representatives not to be fully informed of the facility's deficient practices and how they were corrected.Findings: During an interview conducted during the Resident Council Meeting on 7/1/2025 at 10:30 a.m., Residents 21 and Resident 79 stated they were not aware of the availability and location of the survey results and how the facility corrected the deficiencies that were identified in the past survey. The residents stated they would like to know the facility's latest survey inspection results and the corrections that the facility put into place. During a concurrent observation and interview on 7/1/2025 at 11:30 a.m. with the Activity Director (AD), in the dining room, the survey result binder was under the cabinet in the corner of the dining room. The AD stated the facility had two survey binders, one in the front lobby of the facility for visitors and family members and another one in the dining room. The AD stated the residents were informed that if they (residents) want to see the survey results that they (residents) could always ask the staff. The AD grabbed the survey binder from under the cabinet and verified the label on the binder was too small to be read by the residents. The AD stated the survey binder must be easily accessible to all residents without having to ask the staff. During an interview on 7/1/2025 at 2:15 p.m. with the Administrator (ADM), the ADM stated the survey result binder's label was too small for residents to read. During a concurrent interview and record review on 7/2/2025 at 1:46 p.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Examination of Survey Results, dated 2001 and last reviewed on 1/29/2025, the P&P was reviewed and indicated, A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisit reports, along with state approved plans of corrections of noted deficiencies, is maintained in a three ring binder located in the area frequented by most residents, such as the main lobby or resident activity room. The DON stated the facility failed to let the resident access the survey result binder. The DON stated the survey result was for public access and should be readily accessible to residents and visitors. The DON stated the survey binder results help the family decide if they (family) want to keep their family in the facility or transfer them out. During a review of facility's P&P titled Resident Rights, dated 2/2021 and last reviewed on 1/29/2025, the P&P indicated Employee shall treat all residents with kindness, respect and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to: .w. examine survey results.

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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. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 25) was free from unnecessary use of psychotropic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with facility policy and procedures by failing to ensure:1. Resident 25 had specific, measurable target behaviors monitored related to the use of valproic acid (a psychotropic medication used for bipolar disorder [mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function]) to ensure resident's drug regimen was free from unnecessary medications (any medication in excessive dose, excessive duration, without adequate indication for its use and monitoring).This deficient practice had the potential to place Resident 25 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status.Cross-reference F756 Findings:During a review of Resident 25's admission Record (a document containing demographic and diagnostic information,) dated 7/1/2025, indicated Resident 25 was admitted to the facility on [DATE] with a diagnosis including bipolar disorder. During a review of Resident 25's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 5/10/2025, indicated Resident 25 was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. MDS indicated Resident 25 had no mood, and no behavioral symptoms. During a review of Resident 25's Medication Administration Record (MAR - a record of medications administered to residents), for June 2025, the MAR indicated Resident 25 was prescribed the following: Valproic acid 250 milligram (mg - a unit of measure of mass) to give one (1) capsule by mouth once a day for bipolar disorder manifested by extreme irritability that affects activities of daily living (ADL)s, at 8 a.m. Valproic acid 250 mg to give one (1) capsule by mouth at bedtime for bipolar disorder manifested by extreme irritability that affects ADLs, at 8 p.m.During the same review, the MAR indicated the following: Monitor episodes of bipolar disorder manifested by extreme irritability as evidence of aggressive behavior towards staff that affects ADLs and tally by hashmarks for (valproic acid) use every shift, starting 5/22/2025.The MAR indicated monitoring was documented for three (3) times a day, with two (2) behaviors documented during the day on 6/20/2025, and no behaviors for the remainder of the shifts and days. During a concurrent record review and interview on 7/1/2025 at 2:25 p.m., with Registered Nurse (RN) 2, RN 2 reviewed Resident 25's MAR for June 2025. RN 2 stated Resident 25's valproic acid order prescribed for bipolar disorder manifested by extreme irritability as evidence of aggressive behavior towards staff that affects ADLs, does not have a specific type of irritability or aggressive behavior identified. RN 2 stated there are many different types of irritability and aggressive behavior, such as yelling, hitting, screaming. RN 2 stated psychotropic medications should have indications and monitoring for specific target behaviors to ensure specific behavior monitoring, evaluation of medication effectiveness for specific behavior, and to prevent adverse consequences caused by continuing unnecessary medications. RN 2 stated that without specific targeted behaviors of irritability and aggression different licensed nurses can interpret and document for different behaviors resulting in the physician making an inaccurate assessment of Resident 25's medication therapy leading to the use of unnecessary medication causing adverse consequences and harming the resident. During an interview and concurrent record review on 7/2/2025 at 11:58 a.m., with the Director of Nursing (DON,) the DON reviewed Resident 25's June MAR. The DON stated the valproic acid order for Resident 25 does not include a specific irritability and aggressive behavior to monitor. The DON stated without specific targeted behavior monitoring, assessments and evaluations for the use of valproic acid will be inaccurate, preventing potential medication adjustments, such as lowering the dose or discontinuing the medication leading to unnecessary use and adverse consequences for Resident 25. During a phone interview on 7/2/2025 at 1:13 p.m., with the Pharmacy Consultant (PC,) the PC stated the PC reviewed and completed Resident 25's medication regimen review (MRR) for May and June 2025 and failed to identify the lack of specific behavior monitoring for irritability and aggression with the use of valproic acid in the monthly written reports to the facility. The PC stated not having specific behavior monitoring will lead to inaccurate monitoring and an inability to measure the effectiveness of psychotropic medications, potentially causing unnecessary use and more harm than benefit to Resident 25. During a review of the facility's Policy and Procedures (P&P) titled Behavioral Health Services, last reviewed

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to:1. Develop and implement a comprehensive person-centered care plan (is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one (1) of two (2) sampled residents (Resident 22) reviewed for dignity care area by failing to develop and implement a care plan on the resident's disrobing behavior.2. Ensure to have person-centered care by failing to implement the care plan for one (1) of five (5) residents (Resident 32) reviewed for unnecessary medications (any drug in excess) by failing to implement monitoring for adverse effects (also known as adverse consequences - unwanted, uncomfortable, or dangerous effects that a drug may have) with the use of carbidopa-levodopa (a medication used for Parkinson Disease [a condition that affects movement causing tremors, stiffness, and difficulty with balance and coordination]) for Resident 32, starting 2/3/2025.These deficient practices had a potential for delays in the delivery of necessary care and services that promotes maintenance or enhancement of Resident 22's quality of life, recognizing the resident's individuality; and had the potential to cause Resident 32 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential adverse effects and negatively impacting their physical, mental, and psychosocial well-being. Cross-reference F756 and F757.Findings: During a review of Resident 22’s admission Record (a document containing demographic and diagnostic information,) the admission Record indicated the facility admitted the resident on 12/11/2024, with diagnoses including mood disorder (a mental health condition characterized by significant disturbances in a person's emotional state, leading to prolonged periods of extreme happiness, sadness, or both), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and psychotic disorder (severe mental disorders that cause abnormal thinking and perceptions). During a review of Resident 22’s History and Physical (H&P), dated 12/1/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 22’s Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had severely impaired cognition (a pronounced decline in thinking abilities that significantly impacts daily life, often preventing independent living). The MDS indicated the resident was dependent on lower body dressing while needing partial to moderate assistance on upper body dressing. During a review of Resident 32’s admission Record, dated 7/1/2025, the record indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including Parkinson Disease. During a review of Resident 32’s Care Plan, dated 2/3/2025, the Care Plan indicated: “CARBIDOPA. Resident is at risk for adverse effects from … CARBIDOPA. Monitor for potential risk/effects and alert MD when indicated.” During a review of Resident 32’s Medication Administration Record (MAR - a record of medications administered to residents), for June 2025, the MAR indicated Resident 32 was prescribed: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	· carbidopa-levodopa extended release ([ER] – a formulation of medication designed to deliver a drug slowly over a specific period, rather than all at once, allowing the medication to have a longer effect in the body, providing more consistent drug levels as compared to immediate release tablets) 50-200 milligram (mg – a unit of measure of mass) tablet to give one (1) tablet by mouth midnight for Parkinson Disease. · carbidopa-levodopa 25-100 mg tablet to give one (1) tablet by mouth four (4) times a day for Parkinson Disease, at 8 a.m., 12 p.m., 4 p.m. and 8 p.m. The MAR did not contain documentation for monitoring for adverse effects with the use of carbidopa. During a concurrent observation and interview on 6/30/2025, at 11:08 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 22’s room, observed resident without a shirt on, upper body exposed and the curtain was not drawn. LVN 1 stated the resident tends to remove her clothing and she will help the resident put back her clothes on. During an interview on 6/30/2025, at 11:16 a.m., with Registered Nurse (RN) 2, RN 2 stated she was not aware of Resident 22 removing her clothes. RN 2 stated if she knew the resident was disrobing or removing her clothes, she would have assessed the resident and created a care plan on the disrobing behavior of the resident. During an interview on 6/30/2025, at 11:18 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated Resident 22 had been removing her clothes every time she was changed for two weeks now and he reported the resident’s behavior to his charge nurse. CNA 3 stated he cannot remember anymore who he spoke to but he is sure he had communicated the issue to a licensed staff. CNA 3 stated to his knowledge every time they have a resident that undresses themselves and were confused, the licensed staff created a care plan on the disrobing behavior of the resident to promote resident respect and dignity. During a concurrent record review and interview on 7/1/2025 at 2:15 p.m., with Registered Nurse (RN) 2, RN 2 reviewed Resident 32’s physician orders, June 2025 MAR and Care Plan dated 2/3/2025. RN 2 stated the Care Plan indicated Resident 32 was at risk of adverse effects, such as dyskinesia (uncontrolled, involuntary movements) from the use of carbidopa, and to monitor for potential risk/effects and inform the physician. RN 2 stated monitoring for adverse effects would be documented on the MAR, and that RN 2 was unable to locate documentation for monitoring for adverse effects related to use of carbidopa for Resident 32 for June 2025. The RN 2 stated monitoring for dyskinesia with carbidopa use was important to ensure Resident 32 did not have additional tremors (shaking, movement) that was unnoticed, which may harm the resident further. RN 2 stated the facility failed to ensure to have person-centered care by failing to implement the Care Plan dated 2/3/2025 to accurately reflect the needs of Resident 32; and ensure maintaining the highest level of functionality and quality of life by adequately monitoring the adverse effects related to the use of carbidopa to prevent unnecessary medication use. (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 concurrent record review and interview on 7/2/2025 at 11:58 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 32’s June 2025 MAR and Care Plan dated 2/3/2025. The DON stated the Care Plan indicated Resident 32 was at risk of adverse effects from the use of carbidopa, and to monitor for potential risk/effects and inform the physician. The DON stated the monitoring for adverse effects would be documented on the MAR, and that the DON was unable to locate monitoring for the adverse effects with the use of carbidopa between 6/1/2025 and 6/30/2025 for Resident 32. The DON stated monitoring for adverse effects with the use of carbidopa was important to ensure Resident 32 did not have adverse effects that were unnoticed, which would cause the resident more harm than benefit with the use of carbidopa. The DON stated the facility failed to monitor for adverse effects with the use of carbidopa for Resident 32 by failing to implement the Care Plan dated 2/3/2025 placing the resident at risk of not maintaining their highest level of functionality and quality of life and increasing the risk of adverse effects such as additive tremors. During a phone interview on 7/2/2025 at 1:13 p.m., with the Pharmacy Consultant (PC,) the PC stated Resident 32 should be monitored for adverse effects of carbidopa-levodopa such as dyskinesia. The PC stated not having monitoring for side effects with use of carbidopa-levodopa will lead to the use of unnecessary medications harming Resident 32 by having adverse effects go unnoticed resulting in more harm than benefit to the resident. During an interview on 7/2/2025, at 1:51 p.m., with the DON, the DON stated the facility failed to formulate a care plan and discuss with the interdisciplinary team (IDT, a group of health care professionals with various areas of expertise who work together toward the goals of their clients) members the resident’s behavior of disrobing. The DON stated the licensed staff should have created and implemented a care plan on the resident’s disrobing to ensure they identify the approaches applicable to the resident’s behavior and communicate the issues to all healthcare team to promote dignity and respect on a demented (acting in a confused, irrational, or insane manner) resident. During a review of the facility's recent policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered, last reviewed on 1/29/2025, the P&P indicated a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 7. The comprehensive, person-centered care plan: b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being… e. reflects currently recognized standards of practice for problem areas and conditions.”

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards:1. For one of one sampled resident (Resident 35) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq - beneath the skin) insulin administration sites.2. For one of five sampled residents (Resident 25) reviewed for unnecessary medications by failing to rotate sq insulin administration sites.The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site sq administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F760 Findings: a. During a review of Resident 35’s admission Record, the admission Record indicated the facility originally admitted the resident on 5/24/2023 and readmitted in the facility on 10/21/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), type two diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and long-term use of insulin. During a review of Resident 35’s History and Physical (H&P), dated 10/23/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 35’s Minimum Data Set (MDS - a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 35 was not able to understand others and make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 35 required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 35 received insulin. During a review of Resident 35’s care plan (CP) on risk for hypoglycemia (low level of sugar in the blood) and hyperglycemia (high level of sugar in the blood) related to DM 2, the CP indicated to administer medication as ordered as one of the interventions to prevent unrecognized signs and symptoms of hypoglycemia or hyperglycemia. During a review of Resident 35’s Order Summary Report, the Order Summary Report indicated the following physician’s order: - 4/23/2025 and discontinued on 4/23/2025: Lantus solostar (a long-acting insulin) sq solution pen-injector 100 unit per milliliter (unit/ml – a unit of measurement) inject 10 units subcutaneously at bedtime for DM 2 hold for blood sugar (BS) less than (< - a unit of measurement) 110. May give orange juice (OJ) for BS < 60. Rotate site. - 4/23/2025: Basaglar kwikpen (insulin glargine – a long-acting insulin) sq solution pen-injector 100 unit/ml inject 10 units subcutaneously at bedtime for DM 2 hold for BS <110. May OJ for BS < 60. Rotate site. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/8/2025 and discontinued on 4/23/2025: Humalog kwikpen (a short acting insulin) sq solution pen-injector 100 unit/ml (insulin lispro) inject as per sliding scale (the increasing administration of the pre meal insulin dose based on the blood sugar level before the meal): if 0=150: 0 units. Call physician (MD) if BS <60; 151-200 = 1 unit; 201-250 = two units; 251-300 = three units; 301-350 = four units; 351-400 = five units; 401 plus = six units. Call MD if BS continue to read above 400 subcutaneously three times a day for DM 2 to give 15 minutes before meal. - 4/23/2025: Novolog flexpen (a short acting insulin) sq solution pen injector (insulin aspart) inject as per sliding scale: if 0=150: 0 units. Call physician (MD) if BS <60; 151-200 = one unit; 201-250 = two units; 251-300 = three units; 301-350 = four units; 351-400 = five units; 401 plus = six units. Call MD if BS continue to read above 400 subcutaneously three times a day for DM 2 to give 15 minutes before meal. During a concurrent interview and record review on 7/2/2025 at 10:50 a.m. with the MDS Coordinator (MDSC), Resident 35’s Order Summary Report, CP, and sq administration sites for Basaglar, Lantus, insulin aspart, and insulin lispro from 4/1/2025 to 6/30/2025 were reviewed. The MDSC stated Resident 35 received insulin, had a physician’s order for Basaglar that was changed to Lantus, and insulin lispro that was changed to insulin aspart, and were administered as follows: - Basaglar kwikpen (insulin glargine) sq solution: 4/04/25 7:34 p.m. subcutaneously Abdomen – left lower quadrant (LLQ) 4/05/25 7:51 p.m. subcutaneously Abdomen - LLQ 4/08/25 8:47 p.m. subcutaneously Abdomen – right lower quadrant (RLQ) 4/09/25 8:04 p.m. subcutaneously Abdomen - RLQ 4/16/25 7:15 p.m. subcutaneously Abdomen – left upper quadrant (LUQ) 04/17/25 8:39 p.m. subcutaneously Abdomen – LUQ - Humalog kwikpen (insulin lispro) sq solution: 4/08/25 7:15 p.m. subcutaneously arm - right 4/09/25 8:04 p.m. subcutaneously arm – right - Novolog flexpen sq solution: 5/18/25 12:00 p.m. subcutaneously Arm - left 5/18/25 5:57 p.m. subcutaneously Arm - left (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/20/25 11:15 a.m. subcutaneously Arm - left 5/20/25 5:30 p.m. subcutaneously Arm – left The MDSC stated that the administration sites for insulin should be rotated per standards of practice, manufacturer’s guidelines, and per physician’s order to prevent hardening or lumps in the skin. LVN 3 stated the location of administration sites for Resident 35’s Basaglar, Humalog (insulin lispro), and Novolog (insulin aspart) were not rotated. The MDSC stated there was a physician’s order to rotate administration sites. The MDSC stated Resident 47’s administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident’s skin which can affect the absorption of the insulin. During an interview on 7/2/2025 at 10:55 a.m. with Registered Nurse (RN) 4, RN 4 stated that nurses are supposed to rotate the insulin administration sites as indicated in the physician’s order, manufacturer’s guideline, and according to professional standards of practice. RN 4 stated Resident 35’s insulin administration sites should have been rotated as it placed the resident at risk for development of lipodystrophy which may affect the absorption of the insulin and lead to hyperglycemia. b. During a review of Resident 25’s admission Record, the admission Record indicated the facility admitted the resident on 5/5/2025, with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a systemic illness or condition that disrupts normal metabolic processes), DM 2 with diabetic neuropathy (nerve damage caused by diabetes), and long-term use of insulin. During a review of Resident 25’s H&P, dated 5/6/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 25’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in thinking skills that affects daily life). The MDS indicated the resident was on a high-risk drug class hypoglycemic (medicines to control diabetes). During a review of Resident 25’s Order Summary Report, dated 6/21/2025, the Order Summary Report indicated orders for Insulin Aspart Flexpen Subcutaneous Solution Pen- Injector 100 unit/ml (Insulin Aspart). Inject eight units subcutaneously before meals for diabetes. Hold administration of insulin for blood sugar (BS) less than (<) 110 [rotate site] and Lantus SoloStar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine). Inject 35 units subcutaneously one time a day for DM 2. Hold administration of insulin for BS < 110 [rotate sites]. During a review of Resident 25’s CP Report regarding the resident being at risk for hypoglycemia and hyperglycemia related to DM 2, last revised on 5/18/2025, the CP indicated an intervention to administer medications as ordered. During a review of Resident 25’s Location of Administration Report of Insulin for 5/2025 through 6/2025, indicated: -Lantus Solo Star Subcutaneous Solution Pen-injector 100 unit/ml was administered on (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/6/2025 at 9:19 a.m. on the Abdomen- LLQ 5/7/2025 at 8:19 a.m. on the Abdomen-LLQ 5/21/2025 at 7:45 a.m. on the Deltoid-right 5/22/2025 at 7:34 a.m. on the Deltoid-right -Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 unit/ml on 5/14/2025 at 5:22 p.m. on the Arm-left 5/15/2025 at 8 a.m. on the Arm-left 6/23/2025 at 5:23 p.m. on the Abdomen-LLQ 6/24/2025 at 6:52 a.m. on the Abdomen-LLQ During a concurrent interview and record review on 7/1/2025 at 3:20 p.m. with RN 3, Resident 25’s Medical Diagnosis, Order Summary Report, Location of Administration of Insulin, for 5/2025 through 6/2025, and Care Plan were reviewed. RN 3 stated there were multiple instances where the licensed nurses did not rotate the insulin administration sites for Resident 25. RN 3 stated the licensed staff should rotate insulin administration sites to prevent lipodystrophy that can affect the absorption of insulin if injected on the sites of lipodystrophy. During an interview on 7/2/2025 at 1:51 p.m. with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the sites of insulin administration on Resident 25. The DON stated the sites of administration should be rotated to prevent discomfort, irritation, and lipodystrophy of the frequented sites of administration of insulin. The DON stated the staff should check the electronic healthcare record of the last site of administration of the insulin prior to administering them to prevent repetition of sites of administration. The DON stated that not rotating insulin administration sites on Resident 25 can lead to malabsorption (difficulty in the digestion or absorption of medication) of the insulin that can cause hypo (low) or hyperglycemia on the resident. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 1/29/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Re-check that the amount of insulin drawn into the syringe matches the amount of insulin ordered. - Insulin may be injected into the sq tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. - Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided manufacturer’s guideline for Basaglar (insulin glargine) injection solution, undated, the manufacturer’s guideline indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided manufacturer’s guideline for injection insulin aspart injection, for sq or intravenous use, undated, the manufacturer’s guideline indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of Prescribing Information on the use of Lantus (insulin glargine), with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injury (also called pressure ulcer, localized damage to the skin and/or underlying tissue usually over a bony prominence) for two of two sampled residents (Resident 6 and 10) investigated under pressure injury by:1. Failing to ensure Resident 6's bilateral heel protectors (protective cushions or coverings for the heels) were applied on the resident as ordered by the physician.2. Failing to ensure Resident 10's low air loss mattress (LALM - a mattress that helps prevent and treat pressure injuries by circulating air and relieving pressure on the body) was set according to resident's weight or comfort.These deficient practices had the potential for the development and worsening of pressure injuries to residents. Findings: a. During a review of Resident 6’s admission Record, the admission Record indicated the facility originally admitted Resident 6 on 8/23/2019 and readmitted in the facility on 5/5/2023, with diagnoses including pressure ulcer stage three (full-thickness loss of skin, dead and black tissue may be visible) of sacral (a large, triangular bone at the bottom of the spine) region, contracture (tightness in the tissues around a joint that limits its ability to move freely) of both elbows and both knees, and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 6’s History and Physical (H&P - a medical examination that involves a doctor taking a resident’s medical history, performing a physical exam, and documenting their findings), dated 5/192025, the H&P indicated Resident 6 did not have the capacity to understand and make decisions. During a review of Resident 6’s Minimum Data Set (MDS - a resident assessment tool), dated 5/14/2025, the MDS indicated Resident 6 was not able to understand others and make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 6 required total assistance from staff with all activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 6 had stage three pressure injury. During a review of Resident 6’s Order Summary Report, dated 5/31/2024, the Order Summary Report indicated a physician’s order to apply heel protectors to both feet when in bed and when out of bed in wheelchair for skin breakdown prevention management every shift. During a review of Resident 6’s care plan (CP) on skin integrity impairment, initiated on 10/29/2024 and last revised on 5/29/2025, the CP indicated to apply pressure relieving devices as appropriate and/or as one of the interventions to resolve stage three pressure injury on the sacral region without complications. During a review of Resident 6’s Braden Scale (a tool designed to assess a resident’s risk of developing pressure injuries), dated 5/14/2025, the Braden Scale indicated Resident 6 was a high risk for developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/30/2025 at 2:30 p.m. inside Resident 6’s room, Resident 6 laid in bed with eyes open but does not respond verbally. Resident 6 did not have heel protectors on both feet. During a concurrent observation and interview on 7/1/2025 at 2:20 p.m. inside Resident 6’s room with Certified Nursing Assistant (CNA) 6, CNA 6 stated Resident 6 did not have heel protectors on both feet. CNA 6 stated she was familiar with Resident 6 and had never used the heel protectors on the resident. CNA 6 stated she was not aware if the resident had an order to apply heel protectors. CNA 6 stated she placed a pillow in between Resident 6’s legs as one of the interventions to prevent pressure injury but had not applied the heel protectors. CNA 6 stated the heel protectors should have been applied on Resident 6 if there was a physician’s order to prevent skin breakdown as the resident was a very high risk for pressure ulcers. During a concurrent observation and interview on 7/1/2025 at 2:31 p.m. inside Resident 6’s room with Licensed Vocational Nurse (LVN) 4, LVN 4 stated Resident 6 did not have heel protectors on both feet. LVN 4 stated any pressure relieving devices such as heel protectors and LALM are part of the Treatment Administration Record (TAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) and he is responsible for ensuring that the heel protectors are in place and the LALM setting was in the correct setting according to physician’s orders. LVN 4 stated Resident 6’s bilateral heel protectors should have been applied as ordered by the physician as it placed Resident 6 at risk for development or worsening of pressure injuries considering the resident’s condition such as fragile skin, contracture of both upper and lower extremities, and not eating well. During an interview on 7/2/2025 at 11:45 a.m. with Registered Nurse (RN) 4, RN 4 stated Resident 6 had a physician’s order to apply heel protectors on both feet when in bed and when out of bed in wheelchair for skin breakdown prevention and management as Resident 6 was a high risk for pressure ulcers due to the resident’s condition such as fragile skin, contracture of both upper and lower extremities, and not eating well. RN 4 stated the licensed nurse or CNA assigned to Resident 6 should have ensured that the heel protector was applied on Resident 6 as ordered by the physician. b. During a review of Resident 10’s admission Record, the admission Record indicated the facility originally admitted Resident 10 on 11/2/2020 and readmitted in the facility on 12/22/2020, with diagnoses including dementia (a progressive state of decline in mental abilities), type 2 diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 10’s H&P, dated 12/22/2023, the H&P indicated Resident 10 did not have the capacity to understand and make decisions. During a review of Resident 10’s MDS, dated [DATE], the MDS indicated Resident 10 was not able to understand others and make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 10 required total assistance from staff with all ADLs. During a review of Resident 10’s Order Summary Report, the Order Summary Report indicated the following physician’s orders: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 6/25/2025: Right gluteus (a group of three muscles commonly known as the buttocks) stage four pressure injury (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). Cleanse with normal saline (NS - a saltwater solution), pat dry, apply santyl (an ointment used to help clean wounds and promote healing) and pack with alginate (a type of wound dressing which absorbs fluid resulting in gels the wound moist and minimize bacterial infections), cover with border gauze dressing every day shift for wound care management for four weeks. - 3/7/2025: LALM: Setting is based on resident's current weight, adjust as indicated and it should be on alternating mode pressure setting; some are on automatic alternating setting. During a review of Resident 10’s CP on risk for developing pressure sore, and other types of skin breakdown, initiated on 11/15/2020 and last revised on 3/17/2025, the CP indicated LALM with settings based on the resident’s current weight as one of the interventions to minimize the risk of skin breakdown or pressure sore daily. During a review of Resident 10’s Weights and Vitals Summary, dated 6/4/2025, the Weights and Vitals Summary indicated that Resident 10’s current weight was 114 pounds (lbs. – a unit of measurement). During a review of Resident 10’s Braden Scale, dated 5/30/2025, the Braden Scale indicated Resident 10 was a moderate risk for developing pressure injuries. During an observation on 6/30/2025 at 10:47 a.m. inside Resident 10’s room, observed Resident 10’s LALM with the setting at 160 lbs. The LALM indicated increments of 40 lbs. for each setting starting at 80 lbs. During a concurrent observation, interview, and record review on 6/30/2025 at 11 a.m. with the Infection Preventionist (IP) inside Resident 10’s room, the IP stated Resident 10’s LALM was set at 160 lbs. and the resident’s current weight, dated 6/4/2025, was 114 lbs. The IP stated the setting of the LALM was in increments of 40 lbs. starting at 80 lbs. then followed by 120 lbs., 160 lbs., 200 lbs., up to maximum of 400 lbs. The IP stated Resident 10 did not look like 160 lbs. The IP stated if Resident 10’s current weight was 114 lbs., the LALM should have been set to 120 lbs. as it was closest setting according to the resident’s weight. The IP stated 160 lbs. might be firm for Resident 10 and it placed the resident at risk for worsening of the pressure injury considering the resident’s frail condition and fragile skin. During an interview on 7/2/2025 at 2:58 p.m. with the Director of Nursing (DON), the DON stated LALM should be set according to the resident’s current weight and licensed nurses are supposed to ensure that the setting was correct. The DON stated she was made aware that Resident 10’s LALM was set at 160 lbs. instead of 120 lbs. which was the closest setting according to Resident 10’s current weight of 114 lbs. The DON stated Resident 10’s LALM should have been set to 120 lbs. The DON stated if the setting was placed on a firmer setting, it had the potential for further skin breakdown, affect the healing process, and/or worsening of the current pressure injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility’s policy and procedure (P&P) titled, “Prevention of Pressure Injuries,” last reviewed on 1/29/2025, the P&P indicated to review the resident’s CP and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The P&P further indicated to select the appropriate support surfaces based on the resident’s risk factors, in accordance with current clinical practice. During a review of the facility’s P&P titled, “Support Surface Guidelines,” last reviewed on 1/29/2025, the P&P indicated to provide guidelines for the assessment of appropriate pressure reducing and relieving devices for residents at risk of skin breakdown. The P&P further indicated: - General Guidelines: 1. Redistributing support surfaces are to promote comfort for all bed or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. - Interventions/Care Strategies: 6. Monitor for pressure ulcer risk factors and provide interventions as needed. During a review of the facility provided operations manual for LALM 1, the operations manual indicated: - The LALM 1 system is intended to reduce the incidence of pressure ulcers while optimizing patient comfort. - Users can adjust the air mattress to the desired firmness according to a patient’s weight or the suggestion from a healthcare professional. The operations manual indicated to press the up/down buttons on the panel to adjust the weight or pressure level to the patient’s specific requirements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for seven of seven sampled Residents (Residents 24, 12, 45, 10, 34, 57, and 59) reviewed for accidents by failing to ensure:1. Residents 24, 12, 45, 10, and 34's fall mattress/floor mat (a cushioned floor pad designed to help prevent injury should a person fall) did not have any furniture or medical equipment on top of them.2. Residents 57's and 59's bed controller (device used to change the height and angle of the bed) cord did not have visible wires. (Cross Reference F908)These deficient practices increased the risk of accidents such as falls with injuries and electric shock on residents.Findings: 1. During a review of Resident 24’s admission Record, the admission Record indicated the facility admitted the resident on 4/28/2017, and readmitted the resident on 2/27/2022, with diagnoses including Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of right and left elbow, and contracture of left knee. During a review of Resident 24’s History and Physical (H&P), dated 10/15/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 24’s Minimum Data Set (MDS, a resident assessment tool), dated 4/7/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a significant decline in a person's ability to think, learn, remember, and make decisions). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 24’s Order Summary Report, dated 10/7/2022, the Order Summary Report indicated an order for low bed (a bed frame that sits closer to the ground than a standard bed) with bilateral floor mat to decrease potential injury. (Informed consent obtained from resident/responsible party after explanation of risks and benefits, and verified with MD). Every shift. During a review of Resident 24’s Fall Risk Assessment, dated 4/7/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 24’s Care Plan (CP) Report regarding the resident being at risk for falls/injury, last revised on 10/26/2024, the CP indicated an intervention of low bed with bilateral floor mats as ordered and to provide resident with a safe and clutter-free environment. During a concurrent observation and interview on 6/30/2025, at 9:48 a.m., with the Director of Staff Development (DSD), inside Resident 24’s room, observed Resident 24 with bilateral fall mat and the left fall mat had a chair on top of them. The DSD stated there should be no chair on top of the left side of the resident’s fall mat because when the resident rolls down on the fall mat, the resident will hit the hard surfaces of the chair instead of the mat defeating its purpose to lessen the injury of the resident when they fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/1/2025, at 2:52 p.m., with Licensed Vocational Nurse (LVN) 1, LVN 1 stated there should be no objects on top of the fall mat of Resident 24 because leaving a heavy object on top of the fall mat will create a permanent dent on the fall mat decreasing its capacity to lessen the fall impact. LVN 1 stated if the resident falls down on a fall mat with an object on top of them, the resident can sustain a bruise, skin tear, or even fracture (a break or crack in a bone). During an interview on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON stated there should be no furniture or medical equipment on top of Resident 24’s fall mat. The DON stated placing a furniture or medical equipment on top of the fall mat can cause injury to the resident when the resident rolls down from the bed, instead of landing on the soft surface of the mat, the resident will land on the hard surfaces of the object on top of them causing injuries such as skin tear, laceration (a skin wound), bumps, hematoma (a collection of blood outside of a blood vessel caused by a broken blood vessel), and even fracture. During a review of the facility's recent policy and procedure (P&P) titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. 1. Environment al factors that contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety; g. Electrical safety. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility-provided Instructions on the use of Fall Mat (FM) 1, undated, indicated when moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp objects may cause damage to the mat. Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. 2. During a review of Resident 12’s admission Record, the admission Record indicated the facility admitted the resident on 6/25/2018, and readmitted the resident on 1/6/2025, with diagnoses including Parkinson’s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and contracture of the right and left knees. During a review of Resident 12’s H&P, dated 1/10/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 12’s MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was dependent to needing setup assistance on mobility and ADLs. During a review of Resident 12’s Order Summary Report, dated 1/6/2025, the Order Summary Report indicated an order for low bed with bilateral floor mat to decrease potential injury. (Informed consent obtained from resident/responsible party after explanation of risks and benefits, and verified with MD). Every shift. During a review of Resident 12’s Fall Risk Evaluation, dated 5/29/2025, the Fall Risk Evaluation indicated the resident was not high risk for falls. During a review of Resident 12’s CP Report regarding the resident being at risk for falls/injury, last revised on 6/5/2025, the CP indicated an intervention of low bed with bilateral floor mats as ordered and to provide resident with a safe and clutter-free environment. During a concurrent observation and interview on 7/1/2025, at 9:38 a.m., with LVN 1, inside Resident 12’s room, observed Resident 12’s right fall mat had the wheel of the bed on top of them. LVN 1 stated there should be no objects on top of the fall mat of Resident 12 because leaving a heavy object on top of the fall mat will create a permanent dent on the fall mat decreasing its capacity to lessen the fall impact. LVN 1 stated if the resident falls down on a fall mat with an object on top of them, the resident can sustain a bruise, skin tear, or even fracture. During an interview on 7/2/2025, at 1:51 p.m., with the DON, the DON stated there should be no furniture or medical equipment on top of Resident 24’s fall mat. The DON stated placing a furniture or medical equipment on top of the fall mat can cause injury to the resident when the resident rolls down from the bed, instead of landing on the soft surface of the mat, the resident will land on the hard surfaces of the object on top of them causing injuries such as skin tear, laceration, bumps, hematoma, and even fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. 1. Environment al factors that contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety; g. Electrical safety. During a review of the facility-provided Instructions on the use of FM 1, undated, indicated when moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp objects may cause damage to the mat. Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. 3. During a review of Resident 45’s admission Record, the admission Record indicated the facility admitted the resident on 6/20/2019, and readmitted the resident on 4/2/2024, with diagnoses including age-related osteoporosis (happens as you get older and your bones lose their ability to regrow and reform themselves), history of falling, and history of traumatic fracture (occurs when significant or extreme force is applied to a bone). During a review of Resident 45’s H&P, dated 5/19/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of Resident 45’s MDS, dated [DATE], the MDS indicated the resident usually makes self-understood and understand others and had impaired cognition. The MDS indicated the resident required partial to supervision assistance on mobility and ADLs. During a review of Resident 45’s Order Summary Report, dated 4/3/2024, the Order Summary Report indicated an order for low bed with bilateral floor mat to decrease potential injury. (Informed consent obtained from resident/responsible party after explanation of risks and benefits, and verified with MD). Every shift. During a review of Resident 45’s Fall Risk Assessment, dated 4/3/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 45’s CP Report regarding the resident being high risk for falls/injury, last revised on 10/14/2024, the CP indicated an intervention of low bed with bilateral floor mat to decrease potential injury and provide resident with a safe and clutter-free environment. During a concurrent observation and interview on 6/30/2025, at 11:01 a.m., with Certified Nursing Assistant (CNA) 4, inside Resident 45’s room, observed Resident 45’s fall mat at the right side of the bed had a side table on top of them. CNA 4 stated there should be no objects on top of the fall mat of Resident 45 because leaving a heavy object on top of the fall mat will create a permanent dent on the fall mat decreasing its capacity to lessen the fall impact. CNA 4 stated if the resident falls down on a fall mat with an object on top of them, the resident can sustain a bruise, skin tear, or even fracture. During an interview on 7/2/2025, at 1:51 p.m., with the DON, the DON stated there should be no furniture or medical equipment on top of Resident 45’s fall mat. The DON stated placing a furniture or medical equipment on top of the fall mat can cause injury to the resident when the resident rolls down from the bed, instead of landing on the soft surface of the mat, the resident will land on the hard surfaces of the object on top of them causing injuries such as skin tear, laceration, bumps, hematoma, and even fracture. During a review of the facility's recent P&P titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. 1. Environment al factors that contribute to the risk of falls include: d. obstacles in the footpath. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety; g. Electrical safety. During a review of the facility-provided Instructions on the use of FM 1, undated, indicated when moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. Sharp objects may cause damage to the mat. Never leave heavy objects on mat surface for extended periods, as indentations and damage may occur. 4. During a review of Resident 10’s admission Record, the admission Record indicated the facility originally admitted Resident 10 on 11/2/2020 and readmitted in the facility on 12/22/2020, with diagnoses including dementia (a progressive state of decline in mental abilities), type 2 diabetes mellitus (DM 2-a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of falling. During a review of Resident 10’s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/20/2024, the H&P did not indicate Resident 10’s capacity to understand and make decisions. During a review of Resident 10’s Minimum Data Set (MDS, a resident assessment tool), dated 5/30/2025, the MDS indicated Resident 10 was not able to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 10 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 10’s Order Summary Report, the Order Summary Report indicated a physician’s order dated 6/23/2023 for low bed with bilateral floor mat. During a review of Resident 10’s fall risk evaluations dated 12/3/2024, 3/1/2025, and 5/30/2025, the fall risk evaluations indicated Resident 10 was at risk for falls. During a review of Resident 10’s care plan (CP) on risk for falls initiated on 6/30/2023 and last revised on 6/9/2025, the CP indicated to provide the resident with a safe and clutter-free environment to reduce Resident 10’s risk of falls and/or injury through appropriate interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/30/2025 at 11:23 a.m. inside Resident 10’s room with Certified Nursing Assistant (CNA) 8, CNA 8 stated the wheel of Resident 10’s bed was placed on top of the resident’s right floor mat. CNA 8 stated there should be no furniture or heavy objects on top of the floor mats as the residents as it can affect the integrity of the floor mat and not provide protection for the residents in case of a fall and get injured. CNA 8 stated the wheel of Resident 10’s bed should not have been placed on top of the floor mat as the bed is heavy and can affect the integrity of the floor mat and not protect Resident 10 from getting injured in case of a fall. During an interview on 7/2/2025 at 2:21 p.m. with the Director of Nursing (DON), the DON stated it is not appropriate to have furniture or equipment on top of the fall mats because the heavy object can affect the integrity of the floor mat and unable to provide protection to the resident in case of a fall. The DON stated when the resident rolls down from the bed and the floor mat had damage and indentations, the floor mat is not able to protect the resident and can cause skin tear, laceration (a tear or cut in the skin and underlying tissues), bump, (a collection of blood outside of a blood vessel caused by a broken blood vessel), or fracture (a broken bone). During a review of the facility's recent policy and procedure (P&P) titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. - Environmental factors that contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P further indicated: - Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. - Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. - Due to complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety During a review of the facility-provided instructions on the use of Fall Mat (FM) 1, undated, the instructions indicated: - When moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Sharp objects may cause damage to the mat. - Never leave heavy objects on the mat surface for extended periods, as indentations and damage may occur. 5. During a review of Resident 34’s admission Record, the admission Record indicated the facility originally admitted Resident 34 on 9/29/2022 and readmitted in the facility on 6/19/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), contracture of both knees, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 34’s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/19/2025, the H&P did not indicate Resident 34’s capacity to understand and make decisions. During a review of Resident 34s Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2025, the MDS indicated Resident 34 was not able to understand others and make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 34 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 34’s Order Summary Report, the Order Summary Report indicated a physician’s order dated 6/19/2024 for low bed with bilateral floor mat. During a review of Resident 34’s fall risk evaluations dated 10/2/2024, 12/31/2024, and 3/28/2025, the fall risk evaluations indicated Resident 34 was at risk for falls. During a review of Resident 34’s care plan (CP) on risk for falls initiated on 10/7/2022 and last revised on 10/14/2024, the CP indicated to provide resident with a safe and clutter-free environment and low bed with bilateral floor mat as a few of the interventions to reduce Resident 34’s risk of falls and injury. During a concurrent observation and interview on 6/30/2025 at 10:44 a.m. inside Resident 34’s room with Certified Nursing Assistant (CNA) 8, CNA 8 stated the wheel of Resident 34’s bed was placed on top of the resident’s right floor mat. CNA 8 stated there should be no furniture or heavy objects on top of the floor mats as the residents as it can affect the integrity of the floor mat and not provide protection for the residents in case of a fall and get injured. CNA 8 stated the wheel of Resident 34’s bed should not have been placed on top of the floor mat as the bed is heavy and can affect the integrity of the floor mat and not protect Resident 34 from getting injured in case of a fall. (continued on next page)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/2/2025 at 2:21 p.m. with the Director of Nursing (DON), the DON stated it is not appropriate to have furniture or equipment on top of the fall mats because the heavy object can affect the integrity of the floor mat and unable to provide protection to the resident in case of a fall. The DON stated when the resident rolls down from the bed and the floor mat had damage and indentations, the floor mat is not able to protect the resident and can cause skin tear, laceration (a tear or cut in the skin and underlying tissues), bump, (a collection of blood outside of a blood vessel caused by a broken blood vessel), or fracture (a broken bone). During a review of the facility's recent policy and procedure (P&P) titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. - Environmental factors that contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P further indicated: - Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. - Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. - Due to complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety During a review of the facility-provided instructions on the use of Fall Mat (FM) 1, undated, the instructions indicated: - When moving equipment such as lifts and wheelchairs across the mat, always make sure wheel locks are not engaged, as locked wheels may damage the surface. - Sharp objects may cause damage to the mat. - Never leave heavy objects on the mat surface for extended periods, as indentations and damage may occur. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During a review of Resident 57’s admission Record, the admission Record indicated the facility admitted Resident 57 on 10/1/2021, with diagnoses including dementia (a progressive state of decline in mental abilities), mood disorder (mental health condition causing persistent and intense sadness, elation and/or anger), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 57’s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 2/19/2025, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57’s Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 57 was sometimes able to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 57 required partial/moderate assistance with bed mobility and toilet transfers; total assistance from staff with eating, toileting, and bathing; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 6/30/2025 at 8:44 a.m. inside Resident 57’s room, observed Resident 57 sitting up on the wheelchair. Resident 57’s bed control was placed on top of the bed and observed the base of the bed control with the wires exposed. During a concurrent observation and interview on 6/30/2025 at 2:30 p.m., inside Resident 57’s room with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 57’s bed control had frayed or exposed wires at the base. CNA 7 stated if staff observed any equipment in the resident room is in disrepair, the maintenance department should be notified as soon as possible to have the bed control replaced. CNA 6 stated the maintenance department should have been notified by the staff to change Resident 57’s bed control as soon as possible as the exposed wires placed the resident at risk for electrocution which may lead to injury. During an interview on 7/2/2025, at 11:54 a.m., with the Director of Nursing (DON), the DON stated there should be no frayed/exposed wires on all the resident’s bed controller to prevent accidents such as electrical shock on the residents. The DON stated that the staff during their resident rounds should identify hazards that can cause harm to residents. The DON stated upon observation of the frayed/exposed wires the staff should have reported the incident to the maintenance department for immediate replacement. During a review of the facility's recent policy and procedure (P&P) titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P further indicated maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P further indicated: - Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. - Due to their complexity and scope, certain resident risk facto

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician visited one of three sampled residents (Resident 29) by:1. Failing to ensure the Attending Physician (AP) made an initial face-to-face visit within 30 days for the first 90 days following Resident 29's admission.2. Failing to ensure Resident 29 was seen the Psychiatrist Doctor (Psych MD- a medical doctor specializing in mental health, who can diagnose and treat mental, emotional and behavioral disorders) as per physician order.These failures had the potential to result in an undetected decline in medical, health or psychosocial condition and could lead to a delay in necessary care, treatment and services.Findings: During a review of Resident 29’s admission Record, the admission Record indicated the facility initially admitted Resident 29 on 9/18/2024, and readmitted on [DATE], with diagnoses including cerebral ischemia (a condition where the brain doesn't receive enough blood flow, leading to a lack of oxygen and nutrients, unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and unspecified insomnia (trouble falling asleep or staying asleep)cerebral ischemia. During a review of Resident 29’s Initial Psychiatric Evaluation, dated 10/5/2024, the Initial Psychiatric Evaluation was done and signed by the Psychiatrist Nurse Practitioner 1 (Psych NP 1- refers to a registered nurse who has completed advanced education and training). During a review of Resident 29’s Order Summary Report dated 11/4/2024, the Order Summary Report indicated an order for Psychiatrist consultation with treatment and follow up as indicated. During a review of Resident 29’s History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 11/6/2024, the H&P indicated Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29’s Minimum Data Set (MDS-a resident assessment tool), dated 5/2/2025, the MDS indicated Resident 29’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. During a concurrent interview, and record review on 7/2/2025, at 4:05 p.m., with Registered Nurse 3 (RN 3), Resident 29’s admission Record, and Progress Notes, from 12/17/2024, to 6/17/2025, were reviewed. RN 3 stated Resident 29 was admitted to the facility on [DATE] and was seen by Psychiatrist NP 2 on the following dates: 12/17/2024, 1/16/2025, 2/14/2025, 4/11/2025, 5/16/2025 and 6/17/2025. During an interview on 7/2/2025, at 4:20 p.m., with RN 3, RN 3 stated there was no documentation in Resident 29’s medical record that the AP and the Psych MD came and visited Resident 29 in the facility. RN 3 stated only the NPs of the AP and the Psych MD’s visited Resident 29. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview, and record review on 7/2/2025, at 4:27 p.m., with the Director of Nursing (DON), Resident 29’s History and Physical (H&P), Progress Notes, and policy and procedure (P&P) titled, “Physician Visits” dated 4/2013, and last reviewed on 1/29/2025. The P&P indicated, “The attending physician must visit his/her patients at least once every thirty (30) days for the first ninety (90) days following the resident's admission, and then at least every sixty (60) days thereafter. After the first ninety (90) days, if the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established, but not to exceed every sixty (60) days. A physician assistant or nurse practitioner may make alternate visits after the initial ninety (90) days following admission, unless restricted by law or regulations.” The DON stated there were no H&P and Progress Notes from the AP in Resident 29’s medical record. The DON stated the AP attends monthly visits in the facility but does not see a specific resident. The DON stated the initial Psych MD visit was from NP 1 and should have been from the Psych MD. The DON stated, she (DON) and the Medical Record Director (MRD) should attempt to call the AP and Psych MD to come and visit their residents. The DON stated the facility failed to follow AP and Psych MD required visitation. The DON stated facility may not be able to identify Resident 29 medical issues and could result in delays in care.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) for two of eight sampled residents (Residents 60, and 32) and for one of one inspected medication room (Medication Room Station 1) by:1. Failing to ensure Medication Disposition Log (a record that documents the handling and disposal of medications, ensuring compliance with regulations and maintaining accountability. It details the type of medication, the quantity, the reason for disposal, and the individuals involved in the process) was completed. Resident 60's one extra Augmentin (medication that treats infection) tablet was not logged in the Medication Disposition Log and bubble pack (medications are pre-sorted and sealed into individual compartments) was missing.2. Failing to administer carbidopa-levodopa (a medication used for Parkinson Disease [a condition that affects movement causing tremors, stiffness, and difficulty with balance and coordination]) on time to Resident 32.3. Failing to reconcile (the process of comparing transactions and activity to supporting documentation) one medication emergency kit (eKIT) containing Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs or Controlled Substances [CS]) on 6/2025. These failures resulted to medication errors and had the potential to cause Resident 32 to experience adverse effects (unwanted, uncomfortable effects from a medication) such as dyskinesia (uncontrolled, involuntary movements) and negatively impact their health and well-being, and increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use), and placing the residents at risk of exposure to harmful medications, leading to physical and psychosocial harm, and hospitalization.Findings: a. During a review of Resident 60’s admission Record, the admission Record indicated the facility admitted Resident 60 on 6/5/2025, with diagnoses that included cerebral infarction (a condition where blood flow to the brain is blocked, leading to brain tissue damage or death due to oxygen deprivation), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of Resident 60’s Physician Order, dated 6/5/2025, the Physician Order indicated Augmentin oral tablet 500-125 milligram (mg - metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for UTI, for four days. During a review of the facility’s Pharmacy Delivery, dated 6/5/2025, the Pharmacy Delivery indicated on 6/5/2025, at 10:05 p.m., Licensed Vocational Nurse (LVN) 2 signed and received eight tablets of amoxicillin/clavulanate (Augmentin) 500 -125 mg. During a review of Resident 60’s Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2025, the MAR indicated Resident 60 received Augmentin from 6/6/2025, to 6/9/2025 for a total of seven doses. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 60’s History and Physical (H&P - a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/6/2025, the H&P indicated Resident 60 did not have the capacity to understand and make decisions. During a review of Resident 60’s Minimum Data Set (MDS - a resident assessment tool), dated 6/11/2025, the MDS indicated Resident 60’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 60 was dependent on staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a concurrent observation and interview on 7/2/2025 at 7:42 a.m. with the Infection Preventionist (IP), the facility’s Pharmacy Delivery Receipt, dated 6/5/2025, and Resident 60’s MAR, dated 6/2025, were reviewed. The IP stated the facility received eight tablets of amoxicillin/clavulanate (Augmentin) 500-125mg on 6/5/2025 at 10:05 p.m. The IP stated Resident 60 received only seven tablets of Augmentin from the eight tablets delivered. During a concurrent interview and record reviewed on 7/2/2025 at 8:57 a.m. with the Director of Nursing (DON), Medication Disposition Log, dated 6/2025, was reviewed. The DON stated the remaining one tablet of Augmentin was not listed in the Medication Disposition Log for Resident 60. During a concurrent observation and interview on 7/2/2025 at 9:12 a.m. with the DON, there were two boxes of discontinued medications inside the DON’s office. The DON stated the two boxes of discontinued medications were not yet logged in the Medication Disposition binder. The DON looked into every single medication bubble pack and no bubble pack for Resident 60’s Augmentin was found. The DON stated she (DON) might have discarded the Augmentin and did not log in the Medication Disposition binder. The DON stated before discarding medication it should be logged in the Medication Disposition. During a concurrent interview and record review on 7/2/2025 at 1:46 p.m. with the DON, the facility’s policy and procedure (P&P) titled, “Disposal of Medications and Medication-Related Supplies, dated 1/2013 and last reviewed on 1/29/2025, was reviewed and the P&P indicated, “Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed…. C. non-controlled medication (medication that doesn’t have a high potential for abuse and dependence) destruction occurs in the presence of two licensed nurses. D. The nurse(s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form. 1) Date of destruction 2) Resident's name 3) Name and strength of medication 4) Prescription number (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5) Amount of medication destroyed 6) Signatures of witnesses…. E. Medication is destroyed within 90 days from the date the medication is discontinued. F. The medication disposition form is kept on file in the facility for 3 years.” The DON stated the facility failed to find and explain the missing one tablet of Augmentin. The DON stated the process for medication disposal after the medication was discontinued, was for the nurses to complete and sign the Medication Disposition log indicating the date, time, name and dose of medication and number of tablets left and leave the medication in the locked medication room or in the locked DONs office and DON collects the medication three to four times a week. The DON stated one tablet, even half a tablet should have been disposed properly. b. During a review of Resident 32’s admission Record, the admission Record indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including Parkinson Disease. During a review of Resident 32’s MAR, dated 6/2025, the MAR indicated Resident 32 was prescribed with: • carbidopa-levodopa extended release ([ER] – a formulation of medication designed to deliver a drug slowly over a specific period, rather than all at once, allowing the medication to have a longer effect in the body, providing more consistent drug levels as compared to immediate release tablets) 50-200 mg tablet to give one tablet by mouth at midnight for Parkinson Disease. • carbidopa-levodopa 25-100 mg tablet to give one tablet by mouth four times a day for Parkinson Disease, at 8 a.m., 12 p.m., 4 p.m. and 8 p.m. During a review of Resident 32’s MAR, dated 6/2025, the MAR indicated the carbidopa-levodopa ER 50-200 mg tablet was scheduled and administered at 6:30 a.m. between 6/1/2025, and 6/30/2025. During a concurrent interview and record review on 7/1/2025 at 2:15 p.m. with Registered Nurse (RN) 2, Resident 32’s physician orders and MAR, dated 6/2025, were reviewed. RN 2 stated Resident 32’s physician ordered carbidopa-levodopa ER 50-200 mg tablet to give at midnight. RN 2 stated Resident 32’s carbidopa-levodopa ER 50-200 mg dose was scheduled and administered at 6:30 a.m. between 6/1/2025 and 6/30/2025, not according to the physician orders. RN 2 stated this was considered a medication error. RN 2 stated Resident 32 was at risk of increased side effects such as dyskinesia from administering carbidopa-levodopa ER 50-200 mg tablet at 6:30 a.m. since the resident also was administered carbidopa-levodopa 25-100 mg immediate release tablets, at 8 a.m., 12 p.m., 4 p.m. and 8 p.m. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 7/2/2025 at 11:58 p.m. with the DON, Resident 32’s MAR, dated 6/2025, was reviewed. The DON stated Resident 32’s physician order indicated to administer carbidopa-levodopa ER 50-200 mg tablet at midnight and MAR indicated Resident 32 was administered carbidopa-levodopa ER 50-200 mg tablet at 6:30 a.m. between 6/1/2025 and 6/30/2025. The DON stated the facility failed to administer carbidopa-levodopa ER 50-200 mg according to Resident 32’s physician order placing Resident 32 at risk of harm from additive side effects of receiving carbidopa-levodopa ER 50-200 mg tablet too close to the next dose of carbidopa-levodopa immediate release 25-100 mg tablet at 8 a.m. c. During a concurrent observation and interview on 6/30/2025 at 1 p.m. with LVN 5 in Medication room [ROOM NUMBER], there was one medication eKIT stored in the refrigerator labeled “REF270” containing CMs without an accountability log for the reconciliation of CM inventory at every shift change for 6/2025. LVN 5 stated that all CMs, including medication eKITs containing CMs should be reconciled at every shift. LVN 5 stated that the one eKIT labeled “REF270” containing CMs in Medication Room Station 1 refrigerator was not reconciled at every shift on 6/2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During an interview on 7/2/2025 at 11:58 p.m. with the DON, the DON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated one eKIT labeled “REF270” containing CMs in Medication Room Station 1 was not reconciled at each shift change for 6/2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKITs at each shift change in Medication Room Station 1. During a review of the facility’s P&P titled, “Medication Administration-General Guidelines, ” last reviewed 1/29/2025, the P&P indicated that “Medications are administered as prescribed in accordance with good nursing principles and practices… Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Administration… 2. Medications are administered in accordance with written orders of the attending physician.” During a review of the facility’s P&P titled, “Administering Medications,” last reviewed 1/29/2025, the P&P indicated that “Medications are administered in a safe and timely manner, and as prescribed…. 3. Medications are administered in accordance with prescriber orders, including any required time frame…. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.” During a review of the facility’s P&P titled, “Adverse consequences and Medication Errors, ” last reviewed 1/29/2025, the P&P indicated: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. “A ‘Medication error’ is defined as the preparation or administration of drugs or biologicals which is not in accordance with the prescriber’s order, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 5. Examples of medications error include: l. wrong time.” During a review of the facility’s P&P titled, “Controlled Medication Storage,” last reviewed 1/29/2025, the P&P indicated: “Medications included in the Drug Enforcement Administration classification as CSs are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. A. The DON and the Consultant Pharmacist in collaboration maintain the facility’s compliance with federal and state laws and regulations in the handling of CMs. D. At each shift change, a physical inventory of all CMs, including the emergency supply, is conducted by two licensed nurses and is documented on the CM accountability log. I. The director of nursing in conjunction with the consultant pharmacist or designee routinely monitors CM storage, records, and expiration dates during the medication storage inspection.” During a review of the facility’s P&P titled, “Controlled Substances,” last reviewed 1/29/2025, the P&P indicated: “This facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of CMs. 6. CSs are reconciled upon receipt, administration, disposition, and at the end of each shift. 10. CMs are counted at the end of each shift. The nurse coming on duty and the nurse going off duty determine the count together.”

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the Pharmacy Consultant (PC) failed to identify and report any irregularities in the monthly drug/medication regimen review (MRR) to the attending physician and director of nursing (DON) for one (1) of five (5) sampled residents (Resident 25) reviewed for unnecessary medication (any medication in excessive dose, excessive duration, without adequate indication for its use and monitoring) use by failing to ensure:1. Resident 25 had monitoring for specific, measurable target behaviors related to the use of valproic acid (a psychotropic medication [any medication capable of affecting the mind, emotions, and behavior] used for bipolar disorder [mental health conditions characterized by periodic, intense emotional states affecting a person's mood, energy, and ability to function,]) starting 5/22/2025. 2. Resident 32 had monitoring for medication adverse effects (undesired, unwanted, uncomfortable, or dangerous effects that a drug may have) with the use of carbidopa-levodopa (a medication used for Parkinson Disease [a condition that affects movement causing tremors, stiffness, and difficulty with balance and coordination]) These deficient practices had the potential to cause significant adverse effects from the use of medications not adequately monitored, which could result in impairment or decline in Residents 25's and 32's mental, physical condition, functional, and psychosocial status. Cross-reference F605, F656, F757Findings: During a review of Resident 25’s admission Record (a document containing demographic and diagnostic information,) dated 7/1/2025, indicated Resident 25 was admitted to the facility on [DATE] with a diagnosis including bipolar disorder. During a review of Resident 25’s Minimum Data Set (MDS – a comprehensive resident assessment tool), dated 5/10/2025, indicated Resident 25 was moderately impaired with cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. MDS indicated Resident 25 had no mood, and no behavioral symptoms. During a review of Resident 25’s Medication Administration Record (MAR - a record of medications administered to residents), for June 2025, the MAR indicated Resident 25 was prescribed the following: · Valproic acid 250 milligram (mg – a unit of measure of mass) to give one (1) capsule by mouth once a day for bipolar disorder manifested by extreme irritability that affects activities of daily living (ADL)s, at 8 a.m. · Valproic acid 250 mg to give one (1) capsule by mouth at bedtime for bipolar disorder manifested by extreme irritability that affects ADLs, at 8 p.m. During the same review, the MAR indicated the following: · Monitor episodes of bipolar disorder manifested by extreme irritability as evidence of aggressive behavior towards staff that affects ADLs and tally by hashmarks for (valproic acid) use every shift, starting 5/22/2025. During a review of the May and June 2025 MRR, the May and June 2025 MRR’s did not indicate irregularities identified and reported to the attending physician and DON for Resident 25 by the PC. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 32’s admission Record dated 7/1/2025, indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including Parkinson Disease. During a review of Resident 32’s Care Plan, dated 2/3/2025, the Care Plan indicated: “CARBIDOPA. Resident is at risk for adverse effects from … CARBIDOPA. Monitor for potential risk/effects and alert MD when indicated.” During a review of Resident 32’s MAR for June 2025, the MAR indicated Resident 32 was prescribed: · carbidopa-levodopa extended release ([ER] – a formulation of medication designed to deliver a drug slowly over a specific period, rather than all at once, allowing the medication to have a longer effect in the body, providing more consistent drug levels as compared to immediate release tablets) 50-200 milligram (mg – a unit of measure of mass) tablet to give one (1) tablet by mouth midnight for Parkinson Disease. · carbidopa-levodopa 25-100 mg tablet to give one (1) tablet by mouth four (4) times a day for Parkinson Disease, at 8 a.m., 12 p.m., 4 p.m. and 8 p.m. The MAR did not contain documentation for monitoring for adverse effects with the use of carbidopa. During a review of the April, May and June 2025 MRR, the MRR’s did not indicate irregularities identified and reported to the attending physician and DON for Resident 32 by the PC. During a phone interview on 7/2/2025 at 1:13 p.m., with the PC, the PC stated the PC reviewed and completed Resident 25’s MRR for May and June 2025 and failed to identify the lack of specific behavior monitoring for irritability and aggression with the use of valproic acid in the monthly written reports to the facility. The PC stated not having specific behavior monitoring will lead to inaccurate monitoring and an inability to measure the effectiveness of psychotropic medications, potentially causing unnecessary use and more harm than benefit to Resident 25. During the same interview, the PC stated Resident 32 should be monitored for adverse effects of carbidopa-levodopa such as dyskinesia (uncontrolled, involuntary movements.) The PC stated not having monitoring for side effects with use of carbidopa-levodopa will lead to the use of unnecessary medications harming Resident 32 by having adverse effects go unnoticed resulting in more harm than benefit to the resident. The PC stated the PC reviewed and completed Resident 32’s MRR’s and failed to identify the lack of monitoring for adverse effects with the use of carbidopa in the monthly written reports to the facility. During a review of facility P&P titled “Medication Regimen Review (Monthly Report),” last reviewed 1/29/2025, the P&P indicated “The consultant pharmacist performs a comprehensive MRR at least monthly. The MRR includes evaluating the resident’s response to medication therapy to determine that the resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. B. The consultant pharmacist reviews the MRR of each resident at least monthly either on site or remotely. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	D. Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented and reported to the DON, and/or prescriber as appropriate.” During a review of the facility’s P&P titled “Psychotherapeutic Medications,” last reviewed 1/29/2025, the P&P indicated: “Evaluate the resident’s response to psychotropic medication therapy to determine that the medications are appropriate and resident maintains the highest practicable level of functioning and prevents or minimizes adverse consequences related to medication therapy. M. The pharmacist will complete monthly drug regimen review and give recommendations as indicated and the facility will follow up with the recommendations.” During a review of facility Policy and Procedures (P&P,) titled “Policy for Unnecessary Medication, ” last reviewed 1/29/2025, the P&P indicated: Facility will follow the state and federal regulation to ensure that all residents will be free from … unnecessary drugs. Licensed nurse will review residents’ drug regimen based on the following criteria: 4. Adequate monitoring Facility will include the pharmacist in the QA meeting to discuss the drug regimen review and update the plan if needed. Facility will conduct pharmacy CQI regularly to ensure compliance.” During a review of the facility’s P&P, titled “Adverse consequences and Medication Errors, ” last reviewed 1/29/2025, the P&P indicated: 1. “Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An ‘adverse consequence’ is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual’s mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction b. Side effect 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer’s specifications for use, dose, administration, duration, and monitoring of the medication.”

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that resident's drug regimen was free from unnecessary drugs (any drug in excess) for one (1) of five (5) sampled residents (Resident 32) for unnecessary medication review by failing to:1. Monitor for adverse effects (also known as adverse consequences - unwanted, uncomfortable, or dangerous effects that a drug may have) with the use of carbidopa-levodopa (a medication used for Parkinson Disease [a condition that affects movement causing tremors, stiffness, and difficulty with balance and coordination]) for Resident 32, between 6/1/2025 and 6/30/2025. This deficient practice had the potential to cause Resident 32 to receive suboptimal (less than the highest standard or quality) care leading to the use of unnecessary medications causing potential adverse effects and negatively impacting their physical, mental, and psychosocial well-being. Cross-reference F656 and F756Findings: During a review of Resident 32’s admission Record (a document containing demographic and diagnostic information,) dated 7/1/2025, indicated Resident 32 was admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including Parkinson Disease. During a review of Resident 32’s Care Plan, dated 2/3/2025, the Care Plan indicated: “CARBIDOPA. Resident is at risk for adverse effects from … CARBIDOPA. Monitor for potential risk/effects and alert MD when indicated.” During a review of Resident 32’s Medication Administration Record (MAR - a record of medications administered to residents), for June 2025, the MAR indicated Resident 32 was prescribed: · carbidopa-levodopa extended release ([ER] – a formulation of medication designed to deliver a drug slowly over a specific period, rather than all at once, allowing the medication to have a longer effect in the body, providing more consistent drug levels as compared to immediate release tablets) 50-200 milligram (mg – a unit of measure of mass) tablet to give one (1) tablet by mouth midnight for Parkinson Disease. · carbidopa-levodopa 25-100 mg tablet to give one (1) tablet by mouth four (4) times a day for Parkinson Disease, at 8 a.m., 12 p.m., 4 p.m. and 8 p.m. The MAR did not contain documentation for monitoring for adverse effects with the use of carbidopa. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and interview on 7/1/2025 at 2:15 p.m., with Registered Nurse (RN) 2, RN 2 reviewed Resident 32’s physician orders, June 2025 MAR and Care Plan dated 2/3/2025. RN 2 stated the Care Plan indicated Resident 32 was at risk of adverse effects, such as dyskinesia (uncontrolled, involuntary movements) from the use of carbidopa, and to monitor for potential risk/effects and inform the physician. RN 2 stated monitoring for adverse effects would be documented on the MAR, and that RN 2 was unable to locate documentation for monitoring for adverse effects related to use of carbidopa for Resident 32 for June 2025. The RN 2 stated monitoring for dyskinesia with carbidopa use was important to ensure Resident 32 did not have additional tremors (shaking, movement) that was unnoticed, which may harm the resident further. RN 2 stated the facility failed to ensure to have person-centered care by failing to implement the Care Plan dated 2/3/2025 to accurately reflect the needs of Resident 32; and ensure maintaining the highest level of functionality and quality of life by adequately monitoring the adverse effects related to the use of carbidopa to prevent unnecessary medication use. During a concurrent record review and interview on 7/2/2025 at 11:58 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 32’s June 2025 MAR and Care Plan dated 2/3/2025. The DON stated the Care Plan indicated Resident 32 was at risk of adverse effects from the use of carbidopa, and to monitor for potential risk/effects and inform the physician. The DON stated the monitoring for adverse effects would be documented on the MAR, and that the DON was unable to locate monitoring for the adverse effects with the use of carbidopa between 6/1/2025 and 6/30/2025 for Resident 32. The DON stated monitoring for adverse effects with the use of carbidopa was important to ensure Resident 32 did not have adverse effects that were unnoticed, which would cause the resident more harm than benefit with the use of carbidopa. The DON stated the facility failed to monitor for adverse effects with the use of carbidopa for Resident 32 by failing to implement the Care Plan dated 2/3/2025 placing the resident at risk of not maintaining their highest level of functionality and quality of life and increasing the risk of adverse effects such as additive tremors. During a phone interview on 7/2/2025 at 1:13 p.m., with the Pharmacy Consultant (PC,) the PC stated Resident 32 should be monitored for adverse effects of carbidopa-levodopa such as dyskinesia. The PC stated not having monitoring for side effects with use of carbidopa-levodopa will lead to the use of unnecessary medications harming Resident 32 by having adverse effects go unnoticed resulting in more harm than benefit to the resident. During a review of facility Policy and Procedures (P&P,) titled “Policy for Unnecessary Medication, ” last reviewed 1/29/2025, the P&P indicated: Facility will follow the state and federal regulation to ensure that all residents will be free from … unnecessary drugs. Licensed nurse will review residents’ drug regimen based on the following criteria: 4. Adequate monitoring Facility will include the pharmacist in the QA meeting to discuss the drug regimen review and update the plan if needed. Facility will conduct pharmacy CQI regularly to ensure compliance.” During a review of the facility’s P&P, titled “Adverse consequences and Medication Errors, ” last reviewed 1/29/2025, the P&P indicated: (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. “Residents receiving any medication that has a potential for an adverse consequence will be monitored to ensure that any such consequences are promptly identified and reported. 2. An ‘adverse consequence’ is defined as an unpleasant symptom or event that is due to or associated with a medication, such as an impairment or decline in an individual’s mental or physical condition or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction b. Side effect 4. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer’s specifications for use, dose, administration, duration, and monitoring of the medication.”

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Four (4) medication errors out of 26 total opportunities contributed to an overall medication error rate of 15.38% affecting one (1) of 15 residents observed for medication administration (Resident 81.) The medication errors were as follows:1. Resident 81 received famotidine (a medication used for peptic ulcer disease [PUD - painful sores in the stomach] prophylaxis [prevention,]) hydrochlorothiazide (a medication used for high blood pressure,) losartan (a medication used for high blood pressure,) and buspirone (a medication used for anxiety) at a different time than ordered by Resident 81's physician.These failures had the potential for Residents 81 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have,) and health complications such as stomach pain, uncontrolled blood pressure and anxiety, resulting in Resident 81's health and well-being to be negatively impacted.Findings: During an observation on 6/30/2025 at 09:49 a.m., in Medication Cart Station 2, Licensed Vocational Nurse (LVN) 2 was observed administering famotidine 20 milligram ([mg] – a unit of measure of mass) tablet, buspirone 5 mg tablet, hydrochlorothiazide 12.5 mg tablet and losartan 50 mg tablet orally to Resident 81. Resident 81 was observed swallowing the tablets whole with glass of juice followed by a glass of water. During an interview on 6/30/2025 at 12:08 p.m., with LVN 2, LVN 2 stated that LVN 2 administered famotidine 20 mg, buspirone 5 mg, hydrochlorothiazide 12.5 mg and losartan 50 mg tablets orally that day (6/30/2025) at 9:49 a.m. to Resident 81. LVN 2 acknowledged the physician’s order specified to administer famotidine at 7:30 a.m. and buspirone, hydrochlorothiazide and losartan at 8 a.m. LVN 2 stated, per facility policy, there was a 60-minute window before and after the scheduled time for medication administration and LVN 2 administered the famotidine, buspirone, hydrochlorothiazide and losartan outside that timeframe. LVN 2 stated that LVN 2 failed to follow 5 rights of medication administration and failed to administer famotidine, buspirone, hydrochlorothiazide and losartan to Resident 81 at the correct time of administration. LVN 2 stated these were considered medication errors. During an interview on 7/2/2025 at 1:13 p.m., with the Director of Nursing (DON), the DON stated that LVN 2 failed to administer famotidine, buspirone, hydrochlorothiazide and losartan to Resident 81, at the time scheduled by Resident 81’s physician. The DON stated per facility policy, medications should be administered within a 60-minute window from the time scheduled. The DON stated LVN 2 failed to follow facility medication administration guidelines and 5 rights of medication administration to ensure physician medication orders were administered at the right times to Resident 81. The DON stated these were considered medication errors. The DON stated that it was very important to administer medications as ordered by the physician, since medications are ordered specific to treat a condition and by deviating from that schedule will not help treat the resident’s condition and possibly worsen it. During a review of Resident 81’s admission Record (a document containing demographic and diagnostic information,) dated 6/30/2025 the admission Record indicated Resident 81 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including anxiety, hypertension (high blood pressure) and gastro-esophageal reflux disease (a condition where stomach acid frequently flows back causing irritation and discomfort.) (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 81’s Order Summary Report (a report listing the physician order for the resident,) dated 6/30/2025, the report indicated Resident 81 was prescribed: 1. buspirone 5 mg one (1) tablet orally three (3) times a day for anxiety, starting 4/18/2025. 2. famotidine 20 mg one (1) tablet orally with meals for PUD prophylaxis, starting 4/10/2025. 3. hydrochlorothiazide 12.5 mg one (1) tablet orally in the morning for hypertension, starting 4/11/2025. 4. Losartan 50 mg one (1) tablet orally in the morning for hypertension, starting 4/11/2025. During a review of Resident 81’s ([MAR] - a document of the medications administered to a resident that is part of the resident’s permanent medical record], for June 2025, the MAR indicated Resident 81 was prescribed: 1. buspirone 5 mg one (1) tablet orally three (3) times a day for anxiety, at 8 a.m., 12 p.m. and 4 p.m. 2. famotidine 20 mg one (1) tablet orally with meals for PUD prophylaxis, at 7:30 a.m., 12 p.m. and 5:30 p.m. 3. hydrochlorothiazide 12.5 mg one (1) tablet orally in the morning for hypertension, at 8 a.m. 4. Losartan 50 mg one (1) tablet orally in the morning for hypertension, at 8 a.m. During a review of the facility’s Policy and Procedures (P&P) titled “Medication Administration-General Guidelines,” last reviewed 1/29/2025, the P&P indicated that “Medications are administered as prescribed in accordance with good nursing principles and practices… Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Preparation 3. Prior to administration, the medication ad dosage schedule on the resident’s MAR is compared with the medication label. If the label and MAR are different…the physician’s orders are checked for the correct dosage schedule. Administration 2. Medications are administered in accordance with written orders of the attending physician. 10.Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meals, which are administered based on mealtimes.” During a review of the facility’s P&P titled “Administering Medications,” last reviewed 1/29/2025, the P&P indicated that “Medications are administered in a safe and timely manner, and as prescribed. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Medications are administered in accordance with prescriber orders, including any required time frame. 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). 8. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. During a review of the facility’s P&P, titled “Adverse consequences and Medication Errors, ” last reviewed 1/29/2025, the P&P indicated: 5. “A ‘Medication error’ is defined as the preparation or administration of drugs or biologicals which is not in accordance with the prescriber’s order, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 6. Examples of medications error include: l. wrong time.”

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards):1. For one of one sampled resident (Resident 35) reviewed for insulin (a hormone that lowers the level of glucose [a type of sugar] in the blood) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (beneath the skin) insulin administration sites.2. For one of five sampled residents (Resident 25) reviewed for unnecessary medications by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq - beneath the skin) insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration sites.The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F658Findings: a. During a review of Resident 35’s admission Record, the admission Record indicated the facility originally admitted the resident on 5/24/2023 and readmitted in the facility on 10/21/2024 with diagnoses including dementia (a progressive state of decline in mental abilities), type two diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), and long-term use of insulin. During a review of Resident 35’s History and Physical (H&P), dated 10/23/2024, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 35’s Minimum Data Set (MDS - a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 35 was not able to understand others and make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 35 required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 35 received insulin. During a review of Resident 35’s care plan (CP) on risk for hypoglycemia (low level of sugar in the blood) and hyperglycemia (high level of sugar in the blood) related to DM 2, the CP indicated to administer medication as ordered as one of the interventions to prevent unrecognized signs and symptoms of hypoglycemia or hyperglycemia. During a review of Resident 35’s Order Summary Report, the Order Summary Report indicated the following physician’s order: - 4/23/2025 and discontinued on 4/23/2025: Lantus solostar (a long-acting insulin) subcutaneous solution pen-injector 100 unit per milliliter (unit/ml – a unit of measurement) inject 10 units subcutaneously at bedtime for DM 2 hold for blood sugar (BS) less than (< - a unit of measurement) 110. May give orange juice (OJ) for BS < 60. Rotate site. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 4/23/2025: Basaglar kwikpen (insulin glargine – a long-acting insulin) subcutaneous solution pen-injector 100 unit/ml inject 10 units subcutaneously at bedtime for DM 2 hold for BS <110. May OJ for BS < 60. Rotate site. - 4/8/2025 and discontinued on 4/23/2025: Humalog kwikpen (a short acting insulin) subcutaneous solution pen-injector 100 unit/ml (insulin lispro) inject as per sliding scale (the increasing administration of the pre meal insulin dose based on the blood sugar level before the meal): if 0=150: 0 units. Call physician (MD) if BS <60; 151-200 = one unit; 201-250 = two units; 251-300 = three units; 301-350 = four units; 351-400 = five units; 401 plus = six units. Call MD if BS continue to read above 400 subcutaneously three times a day for DM 2 to give 15 minutes before meal. - 4/23/2025: Novolog flexpen (a short acting insulin) subcutaneous solution pen injector (insulin aspart) inject as per sliding scale: if 0=150: 0 units. Call physician (MD) if BS <60; 151-200 = one unit; 201-250 = two units; 251-300 = three units; 301-350 = four units; 351-400 = five units; 401 plus = six units. Call MD if BS continue to read above 400 subcutaneously three times a day for DM 2 to give 15 minutes before meal. During a concurrent interview and record review on 7/2/2025 at 10:50 a.m., with the MDS Coordinator (MDSC), Resident 35’s Order Summary Report, CP, and subcutaneous administration sites for Basaglar, Lantus, insulin aspart, and insulin lispro, from 4/1/2025 to 6/30/2025, was reviewed. The MDSC stated Resident 35 received insulin, had a physician’s order for Basaglar that was changed to Lantus, and insulin lispro that was changed to insulin aspart, and were administered as follows: - Basaglar kwikpen (insulin glargine) subcutaneous solution: 4/04/25 7:34 p.m. subcutaneously Abdomen – left lower quadrant (LLQ) 4/05/25 7:51 p.m. subcutaneously Abdomen - LLQ 4/08/25 8:47 p.m. subcutaneously Abdomen – right lower quadrant (RLQ) 4/09/25 8:04 p.m. subcutaneously Abdomen - RLQ 4/16/25 7:15 p.m. subcutaneously Abdomen – left upper quadrant (LUQ) 04/17/25 8:39 p.m. subcutaneously Abdomen – LUQ - Humalog kwikpen (insulin lispro) subcutaneous solution: 4/08/25 7:15 p.m. subcutaneously arm - right 4/09/25 8:04 p.m. subcutaneously arm – right - Novolog flexpen subcutaneous solution: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 - Some	5/18/25 12:00 p.m. subcutaneously Arm - left 5/18/25 5:57 p.m. subcutaneously Arm - left 5/20/25 11:15 a.m. subcutaneously Arm - left 5/20/25 5:30 p.m. subcutaneously Arm – left The MDSC stated that the administration sites for insulin should be rotated per standards of practice, manufacturer’s guidelines, and per physician’s order to prevent hardening or lumps in the skin. LVN 3 stated the location of administration sites for Resident 35’s Basaglar, Humalog (insulin lispro), and Novolog (insulin aspart) were not rotated. The MDSC stated there was a physician’s order to rotate administration sites. The MDSC stated Resident 47’s administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident’s skin which can affect the absorption of the insulin. During an interview on 7/2/2025 at 10:55 a.m. with Registered Nurse (RN) 4, RN 4 stated that nurses are supposed to rotate the insulin administration sites as indicated in the physician’s order, manufacturer’s guideline, and according to professional standards of practice. RN 4 stated Resident 35’s insulin administration sites should have been rotated as it placed the resident at risk for development of lipodystrophy which may affect the absorption of the insulin and lead to hyperglycemia. b. During a review of Resident 25’s admission Record, the admission Record indicated the facility admitted the resident on 5/5/2025, with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a systemic illness or condition that disrupts normal metabolic processes), DM 2 with diabetic neuropathy (nerve damage caused by diabetes), and long-term use of insulin. During a review of Resident 25’s History and Physical (H&P), dated 5/6/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 25’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in thinking skills that affects daily life). The MDS indicated the resident was on a high-risk drug class hypoglycemic (medicines to control diabetes). During a review of Resident 25’s Order Summary Report, dated 6/21/2025, the Order Summary Report indicated orders for Insulin Aspart Flexpen Subcutaneous Solution Pen- Injector 100 unit/ml (Insulin Aspart). Inject eight units subcutaneously before meals for diabetes. Hold administration of insulin for blood sugar (BS) < 110 [rotate site] and Lantus SoloStar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine). Inject 35 units subcutaneously one time a day for DM 2. Hold administration of insulin for BS < 110 [rotate sites]. During a review of Resident 25’s Care Plan (CP) Report regarding the resident being at risk for hypoglycemia (a condition in which your blood sugar [glucose] level is lower than the standard range) and hyperglycemia (high blood glucose) related to DM 2, last revised on 5/18/2025, the CP indicated an intervention to administer medications as ordered. (continued on next page)

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Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 - Some	During a review of Resident 25’s Location of Administration Report of Insulin for 5/2025 through 6/2025, indicated: -Lantus Solo Star Subcutaneous Solution Pen-injector 100 unit/ml was administered on 5/6/2025 at 9:19 a.m. on the Abdomen - LLQ 5/7/2025 at 8:19 a.m. on the Abdomen - LLQ 5/21/2025 at 7:45 a.m. on the Deltoid - right 5/22/2025 at 7:34 a.m. on the Deltoid - right -Insulin Aspart FlexPen Subcutaneous Solution Pen-injector 100 unit/ml on 5/14/2025 at 5:22 p.m. on the Arm - left 5/15/2025 at 8 a.m. on the Arm - left 6/23/2025 at 5:23 p.m. on the Abdomen - LLQ 6/24/2025 at 6:52 a.m. on the Abdomen - LLQ During a concurrent interview and record review on 7/1/2025 at 3:20 p.m. with Registered Nurse (RN) 3 Resident 25’s Medical Diagnosis, Order Summary Report, Location of Administration of Insulin, for 5/2025 through 6/2025, and Care Plan were reviewed. RN 3 stated there were multiple instances where the licensed nurses did not rotate the insulin administration sites on Resident 25. RN 3 stated the licensed staff should rotate insulin administration sites to prevent lipodystrophy that can affect the absorption of insulin if injected on the sites of lipodystrophy. During an interview on 7/2/2025 at 1:51 p.m. with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the sites of insulin administration on Resident 25. The DON stated the sites of administration should be rotated to prevent discomfort, irritation, and lipodystrophy of the frequented sites of administration of insulin. The DON stated the staff should check the electronic healthcare record of the last site of administration of the insulin prior to administering them to prevent repetition of sites of administration. The DON stated that not rotating insulin administration sites on Resident 25 can lead to malabsorption (difficulty in the digestion or absorption of medication) of the insulin that can cause hypo (low) or hyperglycemia on the resident. During a review of the facility's recent policy and procedure (P&P) titled Insulin Administration, last reviewed on 1/29/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. The P&P further indicated: - Re-check that the amount of insulin drawn into the syringe matches the amount of insulin ordered. - Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided manufacturer’s guideline for Basaglar (insulin glargine) injection solution, undated, the manufacturer’s guideline indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided manufacturer’s guideline for injection insulin aspart injection, for subcutaneous or intravenous use, undated, the manufacturer’s guideline indicated to rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. During a review of the facility-provided Highlights of Prescribing Information on the use of Lantus (insulin glargine), with initial U.S. approval in 2000, the Highlights of Prescribing Information indicated to rotate injection sites to reduce risk of lipodystrophy and localized cutaneous amyloidosis.

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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 - Some	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 label:1. one (1) budesonide (a medication used to treat and prevent shortness of breath) inhalation solution foil pouch (package made of foil protecting the inhalation solution from light and degradation) for Resident 55 at room temperature in accordance with the manufacturer's requirements in one (1) of one (1) inspected medication carts (Medication Cart Station 1.)2. one (1) budesonide and formoterol (a combination medication used to treat Chronic Obstructive Pulmonary Disease [COPD]- a disease that blocks air flow and makes breathing difficult]) inhalation aerosol (form of medication that is inhaled) for Resident 57 with an open date, in accordance with facility requirements and manufacturer's requirements in one (1) of one (1) inspected medication carts (Medication Cart Station 1.)These deficient practices increased the risk that Residents 55 and 57 could have received medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization or death.Findings: During an observation, on [DATE] at 12:45 p.m., in Medication Cart Station 1, with Licensed Vocational Nurse (LVN) 5, the following medication were found either stored in a manner contrary to their respective manufacturer’s requirements, not labeled with an open date as required by their respective manufacturer’s specifications, or stored and labeled contrary to facility policies: 1. one (1) open budesonide inhalation solution foil (aluminum) pouch (envelope) for Resident 55, was found stored at room temperature and not labeled with a date indicating when the foil pouch was opened. Three (3) inhalation solutions were observed stored in the open foil pouch. According to the manufacturer’s product storage and labeling, opened foil pouch of budesonide inhalation solutions should always be stored in the foil pouch at room temperature between 68 and 77 degrees Fahrenheit and used or discarded within two (2) weeks of opening the foil pouch. 2. One (1) open and used budesonide and formoterol inhalation aerosol for Resident 57 was found stored at room temperature and not labeled with a date on which aerosol inhaler was opened and removed from the foil pouch. According to the manufacturer’s product storage and labeling, budesonide and formoterol inhalation aerosol inhaler should be stored at room temperature between 68 to 77 degrees Fahrenheit and once the foil pouch was removed to be used or discarded within 3 months. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, LVN 5 stated the budesonide inhalation solution foil pouch for Resident 55 in the Medication Cart Station 1 was opened and not labeled with a date indicating when the foil pouch was opened, and three (3) inhalations remained stored in the foil pouch. LVN 5 stated per facility policy multi-dose (containing more than one dose) products such as inhalation solutions should be labeled with the date when first opened to know when they expire, and according to manufacturer guidelines the inhalation solutions once opened from the foil pouch needed to discard within two (2) weeks. LVN 5 stated it was unknown when the three (3) budesonide inhalation solutions would expire and if used beyond the two (2) weeks were considered expired and lost potency (effectiveness), potentially leading to the administration of ineffective medication to Resident 55 causing harm by not treating the asthma (a condition that makes breathing difficult) leading to difficulty in breathing, requiring immediate treatment and potential hospitalization. LVN 5 stated three (3) budesonide inhalation solutions for Resident 55 should be discarded from Medication Cart Station 1. During a concurrent interview, LVN 5 stated the budesonide with formoterol inhaler for Resident 57 in Medication Cart Station 1 was opened, used and not labeled with a date indicating when the inhaler was removed from the foil pouch. LVN 5 stated per facility policy multi-dose products such as inhalation solutions should be labeled with the date when first opened to know when they expire, and according to manufacturer guidelines for budesonide with formoterol inhaler once opened from the foil pouch or overwrap (additional layer of packaging that covers the product,) needed to be discarded within three (3) months. LVN 5 stated it was unknown when the inhaler was opened and when it would expire and if used in error beyond three (3) months was considered expired and lost potency, potentially leading to the administration of ineffective medication to Resident 57 causing harm by not treating the wheezing associated with COPD leading to difficulty in breathing, exacerbating the COPD requiring potential hospitalization. During an interview, on [DATE] at 11:458 p.m., with the Director of Nursing (DON,) the DON stated that breathing inhalation solutions stored in foil pouches should be labeled with a date when opened and removed from the pouch to know when the beyond use date was (a date identifying an expiration date after opening a multi-dose product,) otherwise unable to determine the expiration date. The DON stated budesonide inhalation solutions expire within two (2) weeks of opening the pouch, and budesonide with formoterol inhalers expire within three (3) months opening and storing outside the foil pouch. The DON stated that expired inhalation treatments have lost effectiveness and when administered in error will not treat the asthma or COPD further causing respiratory (related to breathing) distress and stoppage of breathing for Resident 55 and 57 requiring immediate treatment and hospitalization. During a review of the facility’s Policy and Procedures (P&P,) titled “Administering Medications, ” last reviewed [DATE], the P&P indicated that “Medications are administered in a safe and timely manner, and as prescribed. 12.The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.” During a review of the facility’s P&P, titled “Procedure for all Medications,” last reviewed [DATE], the P&P indicated: “To administer medications in a safe and effective manner. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Check expiration date on package/container. When opening a multi-dose container, place the date on the container.” During a review of manufacturer's guide “Instructions for Use” for budesonide with formoterol inhalation aerosol, dated [DATE], the guide indicated “Throw away budesonide with formoterol inhalation aerosol when the counter shows zero (“0”) or 3 months after you take your budesonide with formoterol inhalation aerosol inhaler out of its foil pouch, whichever comes first.” Review of facility’s P&P, titled “Guide for Special Handling of Medications,” last revised [DATE], the P&P listed the following: “Symbicort (brand name for budesonide with formoterol) – Product should be used within 3 months after opening overwrap.”

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow the facility's menu and nutritional adequacy by failing to ensure residents with No Added Salt (NAS, leaves out all salt in preparing and cooking foods) diet were not provided with an extra packet of salt on their meal tray. The deficient practice had the potential for residents to consume more than allowable sodium intake that can affect their medical condition.Findings: During a review of Resident 79’s admission Record, the admission Record indicated the facility admitted the resident on 6/21/2024, and readmitted the resident on 3/25/2025, with diagnoses including chest pain, essential hypertension (occurs when you have abnormally high blood pressure that is not the result of a medical condition), and cardiomegaly (an enlarged heart). During a review of Resident 79’s History and Physical (H&P), dated 3/27/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 79’s Minimum Data Set (MDS, a resident assessment tool), dated 6/16/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a participant who has sufficient judgment, planning, organization, self-control, and the persistence needed to manage the normal demands of the participant's environment). The MDS indicated the resident was on a therapeutic diet (usually a modification of a regular diet). During a review of Resident 79’s Order Summary Report, dated 3/25/2025, the Order Summary Report indicated an order for NAS (No Added Salt) diet. Regular texture, thin consistency. During a review of Resident 21’s admission Record, the admission Record indicated the facility admitted the resident on 12/27/2024, with diagnoses including obesity, essential hypertension, and atherosclerosis of aorta (the buildup of fats, cholesterol and other substances in and on the artery walls). During a review of Resident 21’s H&P, dated 12/29/2024, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 21’s MDS, dated [DATE], the MDS indicated the resident had intact cognition and was on a therapeutic diet. During a review of Resident 21’s Order Summary Report, dated 6/14/2025, the Order Summary Report indicated an order for consistent or controlled carbohydrate diet (CCHO, eating the same amount of carbohydrates every day that helps keep the blood sugar, or glucose levels stable), NAS diet. Mechanical soft texture. Thin consistency, 4 ounces (oz., a unit of weight) cranberry juice at breakfast, replace dessert with fruit for (X) 6 months, replace whole milk with nonfat milk X 6 months. During the Resident Council Meeting on 7/1/2025, at 10:30 a.m., Resident 79 and Resident 21 stated they had been getting extra packets of salt on their meal tray. (continued on next page)

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 7/1/2025, at 12:10 p.m., observed the food trays of the following residents with a packet of salt and pepper added on their trays: 1. During a review of Resident 55’s admission Record, the admission Record indicated the facility admitted the resident on 10/21/2024, and readmitted the resident on 5/21/2025, with diagnosis of essential hypertension. During a review of Resident 55’s H&P, dated 5/22/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 55’s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on a therapeutic diet. During a review of Resident 55’s Order Summary Report, dated 5/22/2025, the Order Summary Report indicated an order for NAS diet. Mechanical soft texture, thin consistency, no milk. 2. During a review of Resident 46’s admission Record, the admission Record indicated the facility admitted the resident on 8/26/2019, and readmitted the resident on 7/29/2022, with diagnoses including moderate protein-calorie malnutrition (s a state where the body doesn't get enough protein and calories (energy) to function properly. It can range from mild to severe, with different impacts on the body) and tremor. During a review of Resident 46’s H&P, dated 8/13/2024, the H&P indicated the resident does not have the capacity to make decisions. During a review of Resident 46’s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition. The MDS indicated the resident was on a therapeutic diet. During a review of Resident 46’s Order Summary Report, dated 12/202/2024, the Order Summary Report indicated an order for NAS. Regular texture, thin consistency, 4 oz. yogurt with breakfast + 4 oz. of cranberry juice with meals. 3. During a review of Resident 10’s admission Record, the admission Record indicated the facility admitted the resident on 11/2/2020, and readmitted the resident on 12/22/2020, with diagnoses including essential hypertension, peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), and atherosclerotic heart disease (a condition where plaque, a buildup of cholesterol and other substances, narrows and hardens the arteries, making it harder for blood to flow to the heart). During a review of Resident 10’s MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was on a therapeutic diet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10’s Order Summary Report, dated 6/27/2025, the Order Summary Report indicated an order for CCHO NAS diet. Puree texture. Thin consistency, large portion, 4 oz. cranberry juice for breakfast. 4. During a review of Resident 68’s admission Record, the admission Record indicated the facility admitted the resident on 11/19/2024, with diagnoses including essential hypertension and heart failure (the heart is unable to pump blood around the body properly). During a review of Resident 68’s H&P, dated 11/20/2024, the H&P indicated the resident does not have the capacity to make decisions. During a review of Resident 68’s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition. The MDS indicated the resident was on a therapeutic diet. During a review of Resident 68’s Order Summary Report, dated 11/19/2024, the Order Summary Report indicated an order for NAS diet. Regular texture, thin consistency, large portions, double protein (per daughter’s request). During an observation and interview on 7/1/2025, at 12:14 p.m., with the Dietary Service Supervisor (DSS), while doing Tray Line observation, observed kitchen staff adding extra packets of salt and pepper on all trays of the residents. The DSS stated the kitchen staff added extra packets of salt and pepper on all the trays. The DSS stated the kitchen staff should have checked the tray ticket of the resident was on a NAS diet. The DSS stated Residents 55, 46, 10, and 68 should have no extra packet of salt on their tray. The DSS stated residents with NAS diet are supposed to have no extra packet of salt on their tray as it could affect their medical condition. The DSS stated continued provision of salt packets to residents on NAS diet could result in increased blood pressure of the residents. During an interview on 7/2/2025, at 1:51 p.m. with the Director of Nursing (DON), the DON stated the facility failed to check the accuracy of the diet orders in the resident’s trays. The DON stated the kitchen staff should have checked residents on NAS diet and not provided an extra packet of salt on the trays. The DON stated the failure of the kitchen staff had the potential for residents to have uncontrolled blood pressure and edema (swelling caused by excess fluid trapped in your body's tissues). During a review of the facility provided “Summer Menu Recipe,” undated, the menu indicated No Added Salt (NAS); regular diet with no salt packet and 2-gram sodium (2 gm Na, often recommended by healthcare providers to help manage conditions such as high blood pressure, heart disease, kidney disease, and fluid retention)- may have small/reg portions only. During a review of the facility's recent policy and procedure (P&P) titled Menu, last reviewed on 1/29/2025, the P&P indicated the menus will be prepared as written using standardized recipes. The Dietary Services Supervisor and cooks are trained and responsible for the preparation and service of therapeutic diets prescribed.

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

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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 - Many	Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety by failing to ensure:1. A container of thickener on the coffee tray was dated.2. A creamer with use by date of 8/15/2025 and a can of open fruit cocktail covered with saran wrap was labeled with an open date.3. A water pitcher with water and thickener (a substance which can increase the viscosity of a liquid without substantially changing its other properties) was labeled with the date it was poured on the pitcher.4. A pitcher with punch dated 6/27/25 and a can of opened sliced jalapenos dated 6/25/25 were discarded.5. A block of ham, a pan of packaged chicken. and bologna in the kitchen refrigerator was dated with the received date.6. A box of popsicle and fruit bars were labeled with an open date.7. A container of strawberry pudding and two 2 cups of uncovered milk, with an open date.8. 1 cup of uncovered fruit punch, with the date poured.9. A pitcher of fruit punch dated 6/20/2025, a pitcher of water with thickener dated 6/20/2025, a can of opened Nacho sliced jalapenos w/ received date of 6/25/25, and a pitcher of water with thickener dated 6/27/2025 were all discarded. These deficient practices had the potential for food-borne illnesses on residents.Findings: During a kitchen tour on 6/30/2025, at 8:05 a.m., with [NAME] 1 (CK 1), inside the Kitchen, observed the following:1. Coffee Cart-Thickener container on the coffee tray with no date.-a creamer with use by date of 8/15/25, with no open date.-a water pitcher with water and thickener with no date.- a pitcher with juice punch, dated 6/27/25. 2. Kitchen Refrigerator- a block of ham on the kitchen refrigerator with no date.-a pack of bologna undated.- a box of popsicles, with no open date.-a box of fruit bar, with no open date.3. Walk-in Refrigerator- a container of strawberry pudding, no date.- 2 cups of uncovered milk, undated.- 1 cup of uncovered fruit punch, undated.- a pitcher of fruit punch dated 6/20/2025.- a pitcher of water with thickener dated 6/20/2025. - a pitcher of water with thickener dated 6/27/2025.- a can of opened Nacho sliced jalapenos w/ received date of 6/25/25 and no open date.- a can of open fruit cocktail covered with saran wrap w/ no open date.- a pan of packaged chicken with no received date. During a concurrent observation and interview on 6/30/2025, at 8:10 am, with [NAME] (CK) 1, CK 1 stated the thickener container should have been dated on when it was poured on the container, the coffee creamer should have been labeled with an open date, the pitcher of water with thickener should have been dated on when it was poured, and the pitcher of fruit punch dated 6/27/25 should have been discarded to ensure the food is safe to consume by the residents. During a concurrent observation and interview on 6/30/2025, at 8:15 a.m., with CK 1, CK 1 stated the block of ham should have been dated with the received date, the pack of bologna should have been dated with the received date, and the popsicles and fruit bar should have been labeled with open date to ensure the food is safe to use. During a concurrent observation and interview on 6/30/2025, at 8:30 a.m., with Dietary Assistant (DA) 1, inside the kitchen, DA 1 stated the food products should be labeled with the date they were received and open date to ensure the food is safe for consumption, the water pitchers and juices should be dated daily, and the outdated pitchers with water and thickener and fruit punch should have been discarded to ensure the residents will not consume them to prevent gastrointestinal (GI, refers to the stomach and intestines, or more broadly, the digestive system) issues. The packs of chicken on a pan should have been dated with a received date. During an interview on 7/1/2025, at 3:43 p.m., with the Dietary Service Supervisor (DSS), the DSS stated food products should be labeled with the date they were received and open date to ensure the food is safe for consumption. The DSS stated the water pitchers and juices should be dated daily, and the outdated pitchers with water and thickener and fruit punch should have been discarded to ensure the residents will not consume them to prevent GI issues, and the packs of chicken on a pan should have been dated with received date. The DSS stated they should have dated and discarded the food products after 3 days opened. The food products should not be left inside the can, they should be transferred to a plastic sealed container and dated to prevent food-borne illnesses. During an interview on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON stated the kitchen staff should follow their procedure for proper handling, storage, dating and labeling, and disposing of food. The DON stated the failure of the staff to properly handle, store, date and label, and dispose of food had the potential for food contamination, medical issues relating to stomach such as diarrhea and vomiting. During a review of the facility's recent policy and procedure (P&P) titled Refrigerator/Freezer Storage, last reviewed on 1/29/2025, the P&P indicated dietary staff will check and record temperatures of all refrigerators and freezers to ensure the equipment is within appropriate temperature for food storage and handling 6. Leftover food or unused

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly. This deficient practice had the potential to attract pests that can bring diseases to all the residents in the facility. Findings: During an observation on 6/30/2025, at 6:46 a.m., observed the facility's blue trash bin's lid was not totally shut due to overfilled trash and the box/cardboard bin was left open with no lid. Pictures taken for reference. During an observation on 7/1/2025, at 7:01 a.m., observed the facility's blue trash bin's lid was not totally shut due to overfilled trash and the box/cardboard bin was left open with no lid. Pictures taken for reference. During an interview and record review on 7/1/2025, at 3:40 p.m., with the Dietary Service Supervisor (DSS), the DSS reviewed the pictures taken on the facility's trash bins. The DSS stated the blue trash bin was not closed shut, and the bin for cardboard boxes were overflowing and not shut closed. The DSS stated the trash bins should be shut closed to prevent attracting rodents to the trash and spreading diseases in the facility. During an interview and record review on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON reviewed the pictures taken on the facility's trash bins. The DON stated the facility failed to follow their policy and procedure on garbage disposal to ensure it is covered to avoid flies, rats, and for pest control. The DON stated the pests can go inside the facility and can cause medical issues, diseases and infestation. During a review of the facility's recent policy and procedure (P&P) titled, Waste Control and Disposal, last reviewed on 1/29/2025, the P&P indicated all waste will be disposed of daily and as needed throughout the day. 2. Trash bins should be covered at all times. 6. Outside garbage bin should be kept closed at all times and surrounding areas must be kept clean. 8. All cardboard boxes will be broken down and disposed of timely. During a review of the facility's recent P&P titled, Pest Control, last reviewed on 1/29/2025, the P&P indicated our facility shall maintain an effective pest control program. Garbage and trash are not permitted to accumulate and removed from the facility daily.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain a complete and accurate medical records in accordance with accepted professional standards for three of eight sampled residents (Residents 22, 32, and 60) reviewed for informed consents (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) and infection control by:1. Failing to document the method used for verification that the physician discussed the risk and benefits of the proposed treatment to Resident 22 and resident representative.2. Failing to ensure Resident 32's informed consent form was completed and accurate prior to signing and acknowledging the form.3. Failing to ensure Augmentin (medication used to treat infection) was documented as administered on 6/5/2025, at 4 p.m. in Resident 60's medical record.These failures had the potential for failing to ensure the residents or representative consented to the proposed treatment and their right to informed consent was honored and respected for Residents 22 and 32. This had the potential to result in confusion in the care and services rendered to Resident 60 and resulted in inaccurate information entered in Resident 60's medical record. Findings: a. During a review of Resident 22’s admission Record, the admission Record indicated the facility admitted the resident on 12/11/2024, with diagnoses including depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 22’s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 12/17/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 22’s Minimum Data Set (MDS, a resident assessment tool), dated 6/9/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 22’s Order Summary Report, dated 4/11/2025, the Order Summary Report indicated an order for Divalproex Sodium (medication used to stabilize mood) oral capsule delayed release sprinkle 125 milligrams (mg- metric unit of measurement, used for medication dosage and/or amount). Give two capsules by mouth at bedtime for mood disorder (a mental health condition characterized by significant disturbances in a person's emotional state, leading to prolonged periods of extreme happiness, sadness, or both) (2 caps= 250 mg) monitor behavior (m/b) uncontrollable anger outbursts interfering with daily living activities. During a review of Resident 22’s Informed Consent, for Divalproex Sodium, dated 4/11/2025, the Informed Consent did not indicate how the information was provided to the resident and/or representative. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 22’s Care Plan (CP) Report, regarding the resident having episodes of mood disorder, last revised on 12/26/2024, the CP indicated an intervention to explain all procedures and involve the family in care if possible/available and encourage to discuss interests/concerns. During a concurrent interview, and record review on 7/1/2025, at 9:10 a.m., with Licensed Vocational Nurse (LVN) 3, LVN 3 reviewed Resident 22’s Medical Diagnosis, Order Summary Report, Informed Consent, and Care Plan. LVN 3 stated the Informed Consent was missing information on how the consent was verified by the licensed nurse. LVN 3 stated the options on how the verification was done was left blank. LVN 3 stated it was important to ensure the mode of verification was filled out to ensure the informed consent was discussed with the resident or resident representative. During a concurrent interview, and record review on 7/1/2025, at 3:31 p.m., with Registered Nurse (RN) 3, RN 3 reviewed Resident 22’s Informed Consent. RN 3 stated the Informed Consent was incomplete, it did not indicate how the consent was verified. RN 3 stated the licensed nurses should check the Informed Consent for accuracy and completeness prior to affixing their signatures. RN 3 stated the failure of the staff to ensure the completeness and accuracy of the Informed Consent predisposes the residents to violation of their right to informed consent. During an interview, and record review on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON reviewed Resident 22’s Informed Consent. The DON stated the consent was not complete because the information on how the consent was verified was not documented. The DON stated the licensed nurse verifying the consent should inspect the consent for its accuracy and completeness prior to affixing their signatures. The DON stated the failure of the staff to ensure the accuracy and completeness of the consent predisposes the resident to violation of the right to informed consent. During a review of the facility's recent policy and procedure (P&P) titled Policy: Informed Consent, last reviewed on 1/29/2025, the P&P indicated to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints. Procedure:… 2. Prior to obtaining Informed Consent, the attending physician and/or prescriber must provide the residents or their representatives with information on the following topics, including but are not limited to: -Treatment Details: Nature and procedures involved in the proposed treatment, including the probable frequency and duration…. 4. Informed consent may be obtained through the following means: -In person -By phone -Via fax (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-By email. During a review of the facility's recent P&P titled Charting and Documentation, last reviewed on 1/29/2025, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care…. 2. The following information is to be documented in the resident medical record: e. Events, incidents or accidents involving the resident. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate…. 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided. b. During a review of Resident 32’s admission Record, the admission Record indicated the facility admitted the resident on 10/25/2024, and readmitted the resident on 1/23/2025, with diagnoses including depression (a mood disorder characterized by persistent feelings of sadness and loss of interest in activities that were once enjoyable), dementia, and anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness). During a review of Resident 32’s H&P, dated 10/25/2024, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 32’s MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in thinking skills that affects daily life). The MDS indicated the resident was on a high-risk drug class antidepressant (prescription medications that help treat depression). During a review of Resident 32’s Order Summary Report, dated 1/23/2025, the Order Summary Report indicated an order for Oxcarbazepine (medication used to calm overactive nerves in the brain) oral tablet 150 mg. Give one tablet by mouth two times a day for mood disorder m/b anger outburst during care that interferes with activities of daily living; ADD: wear gloves when administering. During a review of Resident 32’s Informed Consent for Oxcarbazepine, dated 1/23/2025, the Informed Consent did not indicate the date the consent was signed by the physician and how the informed consent was verified by the licensed nurse. During a review of Resident 32’s CP Report, regarding the resident having episodes of mood disorder, last revised on 11/4/2024, the CP indicated an intervention to explain all procedures and involve the family in care if possible/available and encourage to discuss interests/concerns. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview, and record review on 7/1/2025, at 9:10 a.m., with LVN 3, LVN 3 reviewed Resident 32’s Medical Diagnosis, Order Summary Report, Informed Consent, and Care Plan. LVN 3 stated the Informed Consent had missing information. The date beside the physician’s signature was left blank and the options on how the verification was done were left blank. LVN 3 stated it was important to ensure the signature of the physician is dated to ensure the currency of the informed consent and mode of verification was filled out to ensure the informed consent was discussed with the resident or resident representative. During a concurrent interview, and record review on 7/1/2025, at 3:31 p.m., with RN 3, RN 3 reviewed Resident 32’s Informed Consent. RN 3 stated the Informed Consent was incomplete, it did not have the date the signature of the physician was affixed, and it did not indicate how the consent was verified. RN 3 stated the licensed nurses should check the Informed Consent for accuracy and completeness prior to affixing their signatures. RN 3 stated the failure of the staff to ensure the completeness and accuracy of the Informed Consent predisposes the residents to violation of their right to informed consent. During an interview and record review on 7/2/2025, at 1:51 p.m., with the DON, the DON reviewed Resident 32’s Informed Consent. The DON stated the consent was not complete because the signature of the physician was not dated and the information on how the consent was verified was not documented. The DON stated the licensed nurse verifying the consent should inspect the consent for its accuracy and completeness prior to affixing their signatures. The DON stated the failure of the staff to ensure the accuracy and completeness of the consent predisposes the resident to violation of the right to informed consent. During a review of the facility's recent P&P titled Policy: Informed Consent, last reviewed on 1/29/2025, the P&P indicated to ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints. Procedure: … 2. Prior to obtaining Informed Consent, the attending physician and/or prescriber must provide the residents or their representatives with information on the following topics, including but are not limited to: -Treatment Details: Nature and procedures involved in the proposed treatment, including the probable frequency and duration…. 4. Informed consent may be obtained through the following means: -In person -By phone -Via fax -By email. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Charting and Documentation, last reviewed on 1/29/2025, the P&P indicated all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care…. 2. The following information is to be documented in the resident medical record: e. Events, incidents or accidents involving the resident. 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate…. 7. Documentation of procedures and treatments will include care-specific details, including: a. the date and time the procedure/treatment was provided. c. During a review of Resident 60’s admission Record, the admission Record indicated the facility admitted Resident 60 on 6/5/2025, with diagnoses that included cerebral infarction (a condition where blood flow to the brain is blocked, leading to brain tissue damage or death due to oxygen deprivation), unspecified (unconfirmed) dementia and urinary tract infection (UTI-an infection in the bladder/urinary tract). During a review of Resident 60’s H&P, dated 6/6/2025, the H&P indicated Resident 60 did not have the capacity to understand and make decisions. During a review of Resident 60’s MDS, dated [DATE], the MDS indicated Resident 60’s cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 60 was dependent on staff for activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 60 was on antibiotic (medication used to treat infection). During a review of Resident 60’s Physician Order, dated 6/5/2025, the Physician Order indicated Augmentin oral tablet 500-125 mg, give one tablet by mouth two times a day for UTI, for four days. During a review of Resident 60’s Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2025, the MAR indicated Resident 60 did not received Augmentin on 6/5/2025 at 4 p.m. During a review of facility’s Oral Emergency Drug Supply (Emergency Kit- typically contain a limited supply of commonly used medications and other necessary items to address immediate needs and prevent harm to residents due to delayed access to medications) indicated the facility had four tablets of Augmentin 500-125 mg available. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility’s Emergency Kit Pharmacy Log dated 6/5/2025, the Emergency Kit Pharmacy Log indicated LVN 2 opened the Emergency Kit and removed one tablet of Augmentin 500-125 mg and administered to Resident 60 on 6/5/2025 at 4:15 p.m. During a concurrent interview, and record review on 7/1/2025, at 8:02 a.m., with the Infection Preventionist (IP), Resident 60’s Progress Notes, and Licensed Nurses Notes, dated 6/5/2025 were reviewed. The IP stated the facility admitted Resident 60 on 6/5/2025, at 3:28 p.m. The IP stated Resident 60’s Progress Notes, dated 6/5/2025, timed at 4 p.m., indicated LVN 2 waited for pharmacy to deliver Augmentin. During a concurrent interview, and record review on 7/2/2025, at 7:42 a.m., with the IP, facility’s Oral Emergency Drug Supply, and the Emergency Kit Pharmacy Log, dated 6/5/2025 were reviewed. The IP stated the facility had a supply of four tablets of Augmentin in the Emergency Kit and the Emergency Kit Pharmacy Log dated 6/5/2025, indicated LVN 2 opened the emergency kit and administered Augmentin to Resident 60 on 6/5/2026, at 4:15 p.m. The IP stated LVN 2 should have documented in Resident 60’s MAR on 6/5/2025, at 4:15 p.m., that Augmentin was administered to Resident 60. The IP stated Resident 60’s medical record had inaccurate documentation. The IP stated the facility did not know if Resident 60 received the Augmentin or not. The IP stated the importance of accurate documentation was to complete the antibiotic dose and to know if the antibiotic was effective for Resident 60’s UTI. During a concurrent interview, and record review on 7/2/2025, at 1:46 p.m., with the DON, facility’s P&P, titled “Charting and Documentation”, dated 7/2017, and last reviewed on 1/29/2025, the P&P indicated, “The following information is to be documented in the resident medical record…. b. Medications administered. Documentation in the medical record will be objective, complete and accurate. The DON stated the facility failed to properly document the medication given to Resident 60. The DON stated once medication was administered the nurses need to document accurately in residents MAR so nurses could show medication was given timely as ordered by the physician. The DON stated Resident 60 might have a missed dose if medication was not documented as administered. The DON stated the facility’s P&P indicated to document right after medication administration. During a review of facility’s P&P titled, “Administering Medications”, dated 4/2019, and last reviewed on 1/29/2025, the P&P indicated, “Medications are administered in accordance with prescriber orders, including any required time frame. 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 medical record; a. the date and time the medication was administered b. the dosage; c. the route of administration; d. the injection (the act of administering a liquid, especially a drug, into a person's body using a needle and a syringe) site; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	e. any complaints or symptoms for which the drug was administered; f. any results achieved and when those results were observed; and g. the signature and title of the person administering the drug.”

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to implement infection control practices for one of three sampled staff (Laundry Staff 1 [LS 1]) reviewed for Infection Control by failing to ensure laundry area was kept clean and sanitary. On 7/1/2025 personal belongings (two bags, one sweater, one cellphone and one pair of sunglasses) were noted inside the clean laundry room.This failure had the potential for cross contamination (unintentional transfer of bacteria or germs or other contaminant from one surface to another) and spread infections and illnesses to residents, and staff.Findings: During a concurrent observation, and interview on 7/1/2025, at 7:30 a.m., with the Housekeeping Manager (HSKM), inside the clean laundry room. Observed one black bag, one white printed bag and one black sweater hanging by the door and observed one cellphone and a pair of sunglasses under the air-conditioning unit just beside the table with the folded clean linens. The HSKM stated the personal belongings belong to LS 1. During an interview on 7/1/2025, at 8:02 a.m., with the Infection Preventionist (IP), the IP stated personal belongings are not allowed inside the clean laundry room. The IP stated the laundry room where washed linens and clothes is a clean area, and personal belongings are dirty and should not be in the clean laundry area. The IP stated LS 1 should have placed her (LS 1) personal belongings in the staff breakroom to prevent the spread of infection. During an interview on 7/1/2025, at 9:28 a.m., with LS 1 and translated by Licensed Vocational Nurse 1 (LVN 1), LS 1 stated the two bags, sweater, cellphone and sunglasses all belongs to her (LS 1). During an interview on 7/1/2025, at 10:07 a.m., with the HSKM and translated by LVN 1, the HSKM stated laundry staff were provided with a locker inside the janitor room where they can place their personal belongings. The HSKM stated personal belongings are not allowed in the clean laundry room for infection control. During a concurrent interview, and record review on 7/2/2025, at 1:46 p.m., with the Director of Nursing (DON), facility's policy and procedure (P&P), titled, Soiled Laundry and Bedding, dated 9/2022, and last reviewed on 1/29/2025, the P&P indicated, Employee personal belongings should not be left in a designated area. Should not be stored or left in laundry area/room. The DON stated the facility failed to keep laundry area clean and free from potential infection related to placing of personal belongings. The DON stated the facility needs to provide a small cabinet or built in storage for the contracted (individuals hired by a company for a specific project or period, rather than as permanent employees) laundry staff for their personal belongings. The DON stated LS 1's belongings should not be left in the laundry room. The DON stated the possibility of cross contamination may occur and might result in the spread of infection. During a review of facility's P&P, titled, Departmental (Environmental Services) dated 4/2023, and last reviewed on 1/29/2025, the P&P indicated, Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts.

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement policy for antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) for two of three sampled residents (Residents 60 and 78) by:1. Failing to monitor Resident 60 for the adverse effect (undesired or harmful effects) of Augmentin (medication used to treat infection) on the following dates and times:a. 7 a.m. to 3 p.m. on 6/6/2025, 6/7/2025, 6/9/2025, and 6/12/2025.b. 3 p.m., to 11 p.m. on 6/11/2025, and 6/12/2025.c. 11 p.m. to 7 a.m. on 6/5/2025, 6/6/2025, 6/7/2025, 6/8/2025, 6/10/2025, 6/11/2025. and 6/12/2025.2. Failing to monitor Resident 78 for the adverse effect of Cephalexin (medication used to treat infection) on 6/17/2025. at 3 p.m. - 11 p.m., and 11 p.m. - 7 a.m., and 6/18/2025, at 7 a.m. - 3 p.m., and 3 p.m.- 11 p.m.These failures had the potential to increase antibiotic resistance (inability to respond to a drug) from unnecessary or inappropriate antibiotic use.Findings: a. During a review of Resident 60's admission Record, the admission Record indicated the facility admitted Resident 60 on 6/5/2025, with diagnoses that included cerebral infarction (a condition where blood flow to the brain is blocked, leading to brain tissue damage or death due to oxygen deprivation), unspecified (unconfirmed) dementia (a progressive state of decline in mental abilities) and urinary tract infection (UTI-an infection in the bladder/urinary tract). During a review of Resident 60's History and Physical (H&P- a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 6/6/2025, the H&P indicated Resident 60 did not have the capacity to understand and make decisions. During a review of Resident 60's Minimum Data Set (MDS-a resident assessment tool), dated 6/11/2025, the MDS indicated Resident 60's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 60 was dependent on staff for activities of daily living (ADL-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 60 was always incontinent (unable to control) bowel and bladder functions. During a review of Resident 60's Physician Order, dated 6/5/2025, the Physician Order indicated an order for the resident to receive Augmentin oral tablet 500-125 milligram (mg- metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth two times a day for UTI, for four days. During a review of Resident 60's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 6/2025, the MAR indicated Resident 60 received Augmentin from 6/6/2025, to 6/9/2025. During a concurrent interview, and record review on 7/1/2025, at 8:02 a.m., with the Infection Preventionist (IP), Resident 60's Progress Notes, and Licensed Nurses Notes, dated 6/5/2025 to 6/12/2025 were reviewed. The IP stated Resident 60 was admitted on [DATE] at 3:28 p.m., and Augmentin was started at 4 p. m. The IP stated residents on antibiotic like Augmentin are monitored for the adverse effects every shift (every eight hours) and monitoring are documented in the Progress Notes. The IP stated antibiotic adverse effects are monitored while Resident 60 were on antibiotic from 6/5/2025 to 6/9/2025 (last dose of antibiotic) and until three days after (6/12/2025) the dose was completed. The IP stated Resident 60's Progress Notes from 6/5/2025 to 6/12/2025 did not have any documentation that monitoring for adverse effect of Augmentin was done for Resident 60. The IP stated the facility failed to monitor Resident 60 every shift for the adverse effect of Augmentin. The IP stated the Licensed Nurses Notes had missing documentation on monitoring for Augmentin adverse effect on the following dates and times:a. 7 a.m. to 3 p.m. on 6/6/2025, 6/7/2025, 6/9/2025, and 6/12/2025.b. 3 p.m., to 11 p.m. on 6/11/2025, and 6/12/2025.c. 11 p.m. to 7 a.m. on 6/5/2025, 6/6/2025, 6/7/2025, 6/8/2025, 6/10/2025, 6/11/2025. and 6/12/2025. b. During a review of Resident 78's admission Record, the admission Record indicated the facility admitted Resident 78 on 5/7/2024 with diagnoses that included unspecified encephalopathy, unspecified dementia and UTI. During a review of Resident 78's H&P, dated 7/1/2025, the H&P indicated Resident 78 did not have the capacity to understand and make decisions. During a review of Resident 78's MDS, dated [DATE], the MDS indicated Resident 78's cognitive skills for daily decisions were severely impaired. The MDS indicated Resident 78 needed maximum assistance from staff for eating, dressing and transferring. The MDS indicated Resident 78 was always incontinent for bowel and bladder functions. During a review of Resident 78's Physician Order, dated

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the electrical and patient care equipment in safe operating condition for five of five sampled residents (Residents 19, 64, 44, 57, and 34) reviewed under environmental task by failing to ensure:1. Resident 19's fall mat/floor mat (a cushioned floor pad designed to help prevent injury should a person fall) did not have peeling covers.2. Residents 64, 44, 57, and 34's bed remote control did not have frayed/exposed wires. The deficient practices had the potential for residents to sustain accidents such as electrical shock and falls.Findings: 1. During a review of Resident 19’s admission Record, the admission Record indicated the facility admitted the resident on 5/4/2022, and readmitted the resident on 8/26/2022, with diagnoses including age-related osteoporosis (is a condition where this natural bone thinning becomes severe, making bones weak and brittle, and much more likely to break, often from a minor fall or even a cough or sneeze), history of falling, and presence of right artificial hip joint (also known as a hip prosthesis, is a replacement for a damaged hip joint that helps restore movement and reduce pain). During a review of Resident 19’s History and Physical (H&P), dated 1/17/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 19’s Minimum Data Set (MDS, a resident assessment tool), dated 4/18/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a pronounced decline in thinking abilities that significantly impacts daily life, often preventing independent living). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 19’s Order Summary Report, dated 8/26/2022, the Order Summary Report indicated an order for low bed (bed frame or mattress set that is closer to the floor compared to standard bed frames) with bilateral floor mat to decrease potential injury. (Informed consent obtained from resident/responsible party after explanation of risks and benefits, and verified with MD). Every shift. During a review of Resident 19’s Fall Risk Assessment, dated 4/18/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 19’s Care Plan (CP) Record regarding the resident having impaired visual functioning, last revised on 2/3/2025, the CP indicated an intervention to provide for a safe environment, free of hazards. During a concurrent observation and interview on 6/30/2025, at 10:43 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 19’s room, observed Resident 19’s fall mat at the left side of the resident’s bed with peeling covers. LVN 1 stated the fall mat at the left side of the bed should be replaced as the covering is peeling off already compromising the integrity of the fall mat to prevent injurious falls, and it is not promoting a homelike environment to the resident. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/2/2025, at 1:51 p.m., with the Director of Nursing (DON), the DON stated the fall mat of Resident 19 should not have a peeling cover at it can compromise the fall mat’s ability to decrease the impact of the fall and injury. The DON also stated having a peeling fall mat at the resident’s room does not promote a homelike environment. During a review of the facility's recent policy and procedure (P&P) titled Homelike Environment, last reviewed on 1/29/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. During a review of the facility's recent P&P titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. 1. Environment al factors that contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety; g. Electrical safety. 2. During a review of Resident 64’s admission Record, the admission Record indicated the facility admitted the resident on 1/29/2024, with diagnoses including dementia (a progressive state of decline in mental abilities), hallucinations (a false perception of objects or events involving your senses: sight, sound, smell, touch and taste), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64’s H&P, dated 1/17/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 64’s MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a noticeable decline in thinking skills that affects daily life). During a review of Resident 64’s Fall Risk Assessment, dated 4/29/2025, the Fall Risk Assessment indicated the resident was high risk for falls. During a review of Resident 64’s CP Report regarding the resident being at high risk for falls/injury, last revised on 5/4/2025, the CP indicated an intervention to provide resident with safe and clutter-free environment. During a concurrent observation and interview on 6/30/2025, at 11:02 a.m., with LVN 1, inside Resident 64’s room, observed Resident 64’s bed remote control cord with frayed/exposed wires. LVN 1 stated there should be no exposed/frayed wires on the resident’s bed to prevent accidental electrocution of the resident. LVN 1 stated all staff were responsible in ensuring the resident’s environment is safe, and all potential hazards should be reported immediately to the maintenance department for replacement of defective hospital equipment. During an interview on 7/2/2025, at 1:51 p.m., with the DON, the DON stated the facility failed to ensure there were no defective equipment in the facility. The DON stated Resident 64 should not have a bed remote control with frayed/exposed wires as it can cause electrocution on the resident. The DON stated all staff should check for defective equipment inside the resident’s room and report it immediately to the departments responsible. During a review of the facility's recent P&P titled Homelike Environment, last reviewed on 1/29/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. During a review of the facility's recent P&P titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. 1. Environment al factors that contribute to the risk of falls include: d. obstacles in the footpath. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 2. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: a. Bed safety; g. Electrical safety. 3. During a review of Resident 44’s admission Record, the admission Record indicated the facility admitted the resident on 8/21/2020, with diagnoses including dementia, Alzheimer’s disease (a disease characterized by a progressive decline in mental abilities), and psychosis. During a review of Resident 44’s H&P, dated 10/15/2024, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 44’s MDS, dated [DATE], the MDS indicated the residents sometimes had the ability to make self-understood and understand others and had impaired cognition. During a review of Resident 44’s Fall Risk Evaluation, dated 5/13/2025, the Fall Risk Evaluation indicated the resident was not at risk for falls. During a review of Resident 44’s CP Report regarding the resident being at risk for falls/injury, last revised on 5/27/2025, the CP indicated an intervention to provide a safe and clutter-free environment. During a concurrent observation and interview on 6/30/2025, at 10:20 a.m., with Certified Nursing Assistant (CNA) 5, inside Resident 44’s room, observed Resident 44’s bed remote control cord with exposed/frayed wires. CNA 5 stated there should be no exposed/frayed wires on the resident’s call light cord to prevent accidental electrocution of the resident. CNA 5 stated all staff were responsible for checking the safety of environment of the resident. During an interview on 7/2/2025, at 1:51 p.m., with the DON, the DON stated the facility failed to ensure there were no defective equipment in the facility. The DON stated Resident 44 should not have a bed remote control with frayed/exposed wires as it can cause electrocution on the resident. The DON stated all staff should check for defective equipment inside the resident’s room and report it immediately to the departments responsible. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's recent P&P titled Homelike Environment, last reviewed on 1/29/2025, the P&P indicated residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. During a review of the facility's recent P&P titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Fall and Fall Risk, Managing, last reviewed on 1/29/2025, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to prevent the resident from falling and to try to minimize complications from falling. 1. Environment al factors that contribute to the risk of falls include: d. obstacles in the footpath. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. 4. During a review of Resident 57’s admission Record, the admission Record indicated the facility admitted Resident 57 on 10/1/2021, with diagnoses including dementia (a progressive state of decline in mental abilities), mood disorder (mental health condition causing persistent and intense sadness, elation and/or anger), and schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior). During a review of Resident 57’s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 2/19/2025, the H&P indicated Resident 57 did not have the capacity to understand and make decisions. During a review of Resident 57’s Minimum Data Set (MDS, a resident assessment tool), dated 5/19/2025, the MDS indicated Resident 57 was sometimes able to understand others and make her needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 57 required partial/moderate assistance with bed mobility and toilet transfers; total assistance from staff with eating, toileting, and bathing; substantial/maximal assistance with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 6/30/2025 at 8:44 a.m. inside Resident 57’s room, observed Resident 57 sitting up on the wheelchair. Resident 57’s bed control was placed on top of the bed and observed the base of the bed control with the wires exposed. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/30/2025 at 2:30 p.m., inside Resident 57’s room with Certified Nursing Assistant (CNA) 7, CNA 7 stated Resident 57’s bed control had frayed or exposed wires at the base. CNA 7 stated if staff observed any equipment in the resident room is in disrepair, the maintenance department should be notified as soon as possible to have the bed control replaced. CNA 6 stated the maintenance department should have been notified by the staff to change Resident 57’s bed control as soon as possible as the exposed wires placed the resident at risk for electrocution which may lead to injury. During an interview on 7/2/2025, at 11:54 a.m., with the Director of Nursing (DON), the DON stated there should be no frayed/exposed wires on all the resident’s bed controller to prevent accidents such as electrical shock on the residents. The DON stated that the staff during their resident rounds should identify hazards that can cause harm to residents. The DON stated upon observation of the frayed/exposed wires the staff should have reported the incident to the maintenance department for immediate replacement. During a review of the facility's recent policy and procedure (P&P) titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P further indicated maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P further indicated: -Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. -Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. -Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: g. Electrical safety. 5. During a review of Resident 59’s admission Record, the admission Record indicated the facility originally admitted Resident 59 on 3/1/2022 and readmitted in the facility on 4/30/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), difficulty in walking, and generalized weakness. During a review of Resident 59’s History and Physical (H&P-a medical examination that involves a doctor taking a patient's medical history, performing a physical exam, and documenting their findings), dated 5/1/2025, the H&P indicated Resident 59 did not have the capacity to understand and make decisions. (continued on next page)

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 59’s Minimum Data Set (MDS, a resident assessment tool), dated 6/2/2025, the MDS indicated Resident 59 was able to understand others and make her needs known and had an intact cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 59 required set up or clean-up assistance with eating, substantial/maximal assistance with tub/shower transfers, and partial/moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 6/30/2025 at 11:51 a.m. inside Resident 59’s room, Resident 59 observed lying in bed asleep with the bed control placed on top of the bed. Observed the base of the bed control with the wires frayed or exposed. During a concurrent observation and interview on 6/30/2025 at 12:11 p.m., inside Resident 34’s room with Certified Nursing Assistant (CNA) 9, CNA 9 stated Resident 59’s bed control had frayed or exposed wires at the base. CNA 9 stated she did not realize that Resident 59’s bed control had frayed or exposed wires. CNA 9 stated if staff observed any equipment in the resident room is in disrepair, the maintenance department should be notified as soon as possible to have the bed control replaced. CNA 9 stated the maintenance department should have been notified by the staff to change Resident 59’s bed control as soon as possible as the exposed wires placed the resident at risk for electrocution which may lead to injury. During an interview on 7/2/2025, at 11:54 a.m., with the Director of Nursing (DON), the DON stated there should be no frayed/exposed wires on all the resident’s bed controller to prevent accidents such as electrical shock on the residents. The DON stated that the staff during their resident rounds should identify hazards that can cause harm to residents. The DON stated upon observation of the frayed/exposed wires the staff should have reported the incident to the maintenance department for immediate replacement. During a review of the facility's recent policy and procedure (P&P) titled Maintenance Service, last reviewed on 1/29/2025, the P&P indicated maintenance service shall be provided to all areas of the building, grounds, and equipment. The P&P further indicated maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. During a review of the facility's recent P&P titled Safety and Supervision of Residents, last reviewed on 1/29/2025, the P&P indicated the facility strives to make the environment as free from accident hazards as possible. The P&P further indicated: -Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. -Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes; QAPI reviews of safety and incident/accident data; and a facility-wide commitment to safety at all levels of the organization. -Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: g. Electrical safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555690	A. Building B. Wing	07/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alameda Care Center	925 W. Alameda Ave. Burbank, CA 91506

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 meet the required room size of 80 square feet (sq feet - a unit of measurement) per resident in multiple resident bedrooms for 19 of 34 rooms (Rooms 1, 2, 4, 5, 6, 8, 10, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 25, and 34). This deficient practice had the potential to result in inadequate useable living space for all the residents, negatively impacting the residents' privacy, and inadequate working space for the caregivers.Findings: During a review of the facility provided document titled, Re: Variance for 483.90 (e) (1)(ii) - Physical Environment, dated 6/30/2025, the request for room variance indicated:1. Each room has easy accessibility to the bathroom and shower rooms.2. There is sufficient room between the beds and the foot of the beds to allow wheelchair residents freedom of movement getting in and out of their wheelchairs.The Request for room variance indicated the following rooms did not meet the 80 square feet (sq ft - a unit of measurement) per resident requirement and the waiver request was for the following rooms: room [ROOM NUMBER]: three beds, 238 sq ft room [ROOM NUMBER]: three beds, 228 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 213 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 195 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 212 sq ft room [ROOM NUMBER]: three beds, 209 sq ft room [ROOM NUMBER]: three beds, 217 sq ftThe minimum square footage for a 3-bed resident room should be 240 sq ft. During the initial tour conducted on 6/30/2025 and multiple observations conducted throughout the recertification survey, the observations indicated the square footage of the rooms requested for waiver did not interfere with the care and services provided by the staff. The residents observed had enough space to move about freely inside the rooms and there was enough space for residents' bed, dresser, and resident care equipment. During a concurrent observation and interview on 7/2/2025 at 10:36 a.m. inside room [ROOM NUMBER] with Certified Nursing Assistant (CNA) 6, observed CNA 6 providing care to Resident 10 without any issues and able to move around freely. CNA 6 stated there was no issue or concern related to space in residents' rooms and staff were able to provide resident care with no issues. CNA 6 stated staff were able to move resident wheelchairs or any resident care equipment in the room without any issues. During a general observation of rooms [ROOM NUMBERS] on 6/30/2025 and 7/2/2025, the residents had ample space to move freely inside the rooms. There was sufficient space to provide freedom of movement for the residents and for nursing staff to provide care to the residents. There was also sufficient space for beds, side tables and resident care equipment. During a concurrent interview and record review with the Administrator (Adm), on 7/2/2025 at 3:40 p.m., reviewed the facility provided document titled, , Re: Variance for 483.90 (e) (1)(ii) - Physical Environment, dated 6/30/2025, with the Adm. The Adm confirmed Rooms 1, 2, 4, 5, 6, 8, 10, 12, 14, 16, 17, 18, 19, 20, 21, 22, 23, 25, and 34 had a square footage of less than 80 square feet per resident. The Adm stated the residents have not brought up any concerns related to space in the room. The Adm stated the staff can provide nursing care for the residents without issues. The Adm further stated if a resident brings up concerns regarding the space in the room, the facility could make a room change to accommodate the residents. During a review of the facility's policy and procedure (P&P) titled, Bedrooms, last reviewed 1/20/2025, the P&P indicated residents will be provided with clean, comfortable, and safe bedrooms that meet federal and state requirements. The P&P further indicated bedrooms must measure at least 80 sq ft of space per resident.