

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555690	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER Alameda Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: ^ 1. Kitchen Aide (KA) 1 was not wearing hair net in the kitchen. ^ 2. Two (2) and a half pack of cheese in refrigerator had no date. 3. Seven (7) veggie burger patties in freezer had no date. 4. The facility's Ice Scoop Cleaning Log was missing the time and staff initials from 6/12/2026 to 6/14/2026. These failures had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 83 of 86 residents who received food from the kitchen. ^ Findings: ^ During a concurrent observation and interview on 6/15/2026 at 7:54 a.m. in the kitchen, observed KA 1 was not wearing hair net. KA 1 stated he is not wearing a hair net because he forgot. KA 1 stated he received in-services that he has to always wear the hair net. During a concurrent interview and record review on 6/15/2026 at 8:15 a.m. with the Cook, the facility form titled, Ice Scoop Cleaning Log, for June 2026, was reviewed. The [NAME] stated the form titled, Ice Scoop Cleaning Log, was missing the time and initial for the dates of 6/12/2026, 6/13/2026, and 6/14/2026. ^ The [NAME] stated kitchen staff are required to initial and record the time each time the Ice Scoop is washed and cleaned, which is usually early morning. The [NAME] stated the ice scoop is used to place ice in containers for residents. The [NAME] stated ice scoops should be cleaned to prevent potential contamination of ice. The [NAME] stated without this documentation, there is no confirmation that the Ice Scoop was cleaned. During a concurrent observation and interview on 6/15/2026 at 8:17 a.m. with the [NAME] inside the refrigerator, observed 2 and a half full packs of cheese with no date. The [NAME] stated there are 2 and a half packs of cheese with no date when they were delivered and when it was opened. The [NAME] stated that all items stored in the refrigerator must be dated when they were received and when they were opened from the original packaging. The [NAME] stated the potential outcome of not having these dates recorded is that items may remain in use past their safe timeframe, increasing the risk that the product could be expired and cause harm to residents. The [NAME] stated that any item received should be labeled with both the received date and the open date to ensure staff know how long the item is good for and when it must be discarded. During a concurrent observation and interview on 6/15/2026 at 8:33 a.m. with KA 2 inside the freezer, observed 7 veggie burger patties with no date. KA 2 stated that there were 7 veggie burger patties in the freezer with no date of when it was delivered and when it was opened. KA 2 stated that he does not know when the veggie burgers were received, when they will expire, or when they should be discarded. KA 2 stated per facility policy, all items stored in the freezer must be properly dated to ensure safe use and to prevent expired food from being given to residents. During an interview on 6/15/2025 at 8:43 a.m. with the Dietary Supervisor (DS), the DS stated all staff must wear hair nets in the kitchen to prevent hair from falling into food and causing contamination. The DS (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555690
		If continuation sheet Page 1 of 26

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated all products in the kitchen - refrigerator, dry storage, and freezer- must be labeled with the delivery date and open date to know when items should be discarded and/or expired. The DS stated the potential outcome of using expired food is harm to residents such as food poisoning. The DS stated that staff must clean the ice scoop daily and record the time and their initials when it was cleaned to maintain accurate documentation, and to know when the scoop was last cleaned as required on the ice scoop cleaning log. The DS stated the ice scoop should be properly cleaned to prevent potential illness coming from contaminated ice. During a review of the facility's policy and procedure (P&P) titled, Dating and labeling, last reviewed on 4/15/2026, the P&P indicated to ensure food safety and prevent contamination within the facility, all food items should be properly covered, dated, and labeled in dry storage and refrigerator/freezer area. All items should have the following appropriate dates delivery date -upon receipt, and open date-open containers. During a review of the facility's P&P titled, Sanitation and Infection Control, last reviewed on 4/15/2026, the P&P indicated food service employee will follow infection control policies to ensure the department operates under sanitary condition at all times. A hair net or head covering which completely covers all hair should be worn at all times. During a review of the facility's P&P titled, Ice Machine Cleaning, last reviewed on 4/15/2026, the P&P indicated dietary staff to clean and sanitize the ice scoop and container daily and as needed. Wash ice scoop with soapy water, rinse, sanitize and air dry. Ice scoop will be washed daily.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an informed consent (a process of communication between a person and the health care provider that often leads to agreement or permission for care, treatment, or services) for psychotropic/psychotherapeutic (any drug that affects behavior, mood, thoughts, or perception) drug for one of five sampled resident (Resident 3) who was prescribed Mirtazapine (an antidepressant used to treat depression [mood disorder that causes a constant, heavy feeling of sadness and a loss of interest in things you once enjoyed]). This failure violated the resident's and/or responsible party's right to be fully informed about the care and treatments being provided, as well as the available alternative treatment options. Findings: During a review of Resident 3's Face Sheet (admission Record), the Face Sheet indicated the facility admitted the resident on 11/13/2025 and readmitted on [DATE] with diagnoses including, but not limited to, diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (high blood pressure). During a review of Resident 3's History and Physical Examination (HP - a comprehensive physician's note regarding the assessment of the resident's health status) signed by the attending physician on 1/13/2026, the HP indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated the Resident 3's cognition (can think, learn, remember, use judgement, and make decisions) is severely impaired. The MDS indicated Resident 3 is on high-risk Drug Antidepressant. During a review of Resident 3's Order Summary Report, active orders as of 6/17/2026, the order summary report indicated to give Mirtazapine 15 milligrams (mg - a unit of measure for mass) one (1) tablet by mouth at bedtime for depression starting on 1/30/2026 with no end date. During a review of Resident 3's Medication Administration Record (MAR) from 6/1/2026 to 6/31/2026 the MAR indicated Resident 3 received Mirtazapine oral tablet 15 mg at bedtime for depression from 6/1/2026 to 6/16/2026. During a review of Resident 3's Psychotropic Drug Informed Consent, dated 1/30/2026, the informed consent indicated: a. Prescriber Signature: By signing below, I declare that I have personally examined, provided, and discussed with the Resident and/or Resident's Representative the following material information but not limited to the reason for the treatment, and the nature and seriousness of the Resident's illness. The nature, degree, duration and probability of the side effects and significant risks, commonly known by the health professions. The reasonable alternative treatments and risks, and why the health professional is recommending this treatment. The Resident's and/or Resident's Representative's right to accept or refuse the proposed treatment, and if they consent, their right to revoke their consent for any reason at any time. The possible nonpharmacologic approaches that could address the Resident's needs The lines designated for the physician signature and date were left blank. b. By signing, the licensed nurse is confirming that the Resident or Responsible Party gave their consent to treatment with the psychotropic drug. The lines designated for the licensed nurse's printed name and signature were left blank. During a concurrent interview and record review on 6/17/2026 at 12:04 p.m. with Licensed Vocational Nurse (LVN) 2, Resident 3's medical record, including Psychotropic Drug informed Consent, dated 1/30/2026, was reviewed. LVN 2 stated that Resident 3's Psychotropic Drug Informed Consent for use of mirtazapine did not include the licensed nurse's signature or the name of the nurse who obtained the consent. LVN 2 stated that the informed consent form requires a licensed nurse's signature to verify that the Resident and/or Responsible Party was informed and provided consent for the treatment. LVN 2 (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further stated that because the form did not contain the licensed nurse's name and signature, the consent is not complete and valid. LVN 2 stated informed consent is required per policy to administer any antidepressant. During a concurrent interview and record review on 6/17/2026 at 12:15 p.m. with the Director of Nursing (DON), Resident 3's Psychotropic Drug informed Consent, dated 1/30/2026, was reviewed. The DON stated that Resident 3's Psychotropic Drug Informed Consent form was missing the physician's signature as well as the licensed nurse's name and signature. The DON stated that any resident receiving psychotropic medication must have an informed consent form, which includes the signatures of both the licensed nurse and the physician. The DON stated that Resident 3 is currently receiving mirtazapine, which the facility classifies as an antidepressant medication. According to facility policy, staff are required to obtain informed consent from the resident or responsible party prior to administering such medications. The DON emphasized that it is the resident's and/or responsible party's right to be informed of all treatment. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Drug Informed Consent, last reviewed on 4/15/2026, the P&P indicated to ensure the resident and resident representative are fully informed of benefits, risk, possible side effect before initiating administering the psychotropic the prescriber must sign an informed consent form after explaining all necessary information to the resident or their representative. The licensed nurse will verify the consent information and sign it to confirm its accuracy and complete. During a review of the facility's P&P titled, Psychotropic Medication Use, last reviewed on 4/15/2026, the P&P indicated drugs in the following category are considered psychotropic: Anti-depressants. During a review of the facility's P&P titled, Resident's Right, last reviewed on 4/15/2026, the P&P indicated Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: be informed of, and participate in, their care planning and treatment.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written information concerning the resident's right under state law to make decision concerning medical care and offer assistance in formulating an Advance Directive (AD - a legal document indicating resident preference on end-of-life treatment decisions) to the residents or the resident's responsible party for two out of eight sampled residents (Resident 49 and 90) investigated during review of advance directive care area.^^ This deficient practice had the potential for the facility to not honor the residents' medical decisions regarding end-of-life treatment. Findings: a. During a review of Resident 49's admission Record (AR), the AR indicated the facility admitted the resident on [DATE] with diagnoses including, anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation) and dementia (an umbrella term for a decline in mental ability severe enough to interfere with daily life). During a review of Resident 49's History and Physical (H&P - is the most formal and complete assessment of the patient and the problem), dated [DATE], the H&P indicated that the resident does not have the capacity to understand and make decisions. The H&P also indicated that the resident's daughter is the primary decision maker (PMD). During a concurrent interview and record review on [DATE] at 3:35 p.m. with the Social Services Director (SSD), Resident 49's Advance Directive Acknowledgment (ADA), dated [DATE], was reviewed. The ADA indicated that Resident 49 is not capable of making preferred intensity of care decision at this time. The ADA form did not contain the signature of the PMD to indicate that the form was discussed and written information was provided. The SSD stated that they have not provided the residents or family members with written materials about their rights to formulate an advance directive. The SSD stated that it's only now that their corporate office has provided the facility with brochure to be given to the residents or their responsible parties regarding their rights to formulate an AD. During an interview on [DATE] at 4:55 p.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated that upon admission, the facility needs to inquire from the resident or responsible party if the resident has an advance directive. The SSD stated if there is no existing advance directive, the facility shall provide written information regarding the residents right to formulate and advance directive and offer assistance if the resident or the responsible party would want to formulate an advance directive. The MDSC stated it's a violation of the resident's rights if they are not provided with written information and if no assistance is offered. b. During a review of Resident 90's AR, the AR indicated the facility admitted the resident on [DATE] from a General Acute Care Hospital (GACH) with diagnoses including pulmonary fibrosis (a serious, progressive lung disease that occurs when lung tissue becomes damaged and scarred).^^ (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 90's MDS, dated [DATE], the MDS indicated Resident 90 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 90 was dependent (helper does all the effort; resident does none of the effort to complete the activity) on staff for eating, dressing, and personal hygiene. During a review of Resident 90's H&P, dated [DATE], the H&P indicated the resident does not have the capacity to understand and make decisions. The H&P indicated there was no advance directive executed and Cardiopulmonary Resuscitation status (CPR - emergency life-saving procedure involving chest compressions) was not indicated whether there was to be full CPR or no CPR. During a review of Resident 90's Interdisciplinary Team (a group of healthcare professionals, such as nursing, social services, and dietary who meet with a resident to help the resident to form goals for their healthcare) Notes, dated [DATE], the IDT notes indicated the responsible party attended the IDT meeting. Resident 90's IDT notes did not indicate any code status (whether or not to attempt CPR) for the resident. During a review of Resident 90's Care Plan for Advance Directive, initiated [DATE], the care plan indicated a goal to respect the resident's and family's wishes ongoing until the next assessment. The care plan did not indicate an advance directive was initiated which would include CPR status. The care plan indicated an intervention to respect the resident's and/or family's wishes. During an interview with the Medical Records Director (MRD) on [DATE] at 10 a.m., the MRD stated Resident 90 does not have an advance directive. During a concurrent interview and record review with the Director of Nursing (DON) on [DATE] at 10:35 a.m., Resident 90's medical records were reviewed. The DON stated a resident's code status is discussed with a resident's family and will reflect on the advance directive. The DON stated after the discussion, the resident's doctor will be made aware. Resident 90's H&P, Social Services Assessments, Advance Directive Care Plan, and Resident 90's IDT Notes were reviewed and did not indicate Resident 90's code status. The DON stated Resident 90 should have an advance directive or documentation of Resident 90's code status. The DON stated it is important to have an advance directive or advance directive acknowledgment because it is a resident's right, and so that the licensed nurses will know how to conduct their care for the resident during an emergency. During an interview with the SSD on [DATE] at 11:10 a.m., the SSD stated she emailed Resident 90's responsible party inquiring about an advance directive, but Resident 90's responsible party did not respond. The SSD stated she did not follow up with the family after that. The SSD stated she should have followed up with the responsible party regarding Resident 90's code status. The SSD stated Resident 90's code status should have been discussed during the IDT meeting with the family. The SSD stated this is important so that the licensed nurses will know how to conduct Resident 90's care. During a review of the facility's policy and procedure (P&P) titled, Advance Directives, last reviewed (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], the P&P indicated the following: - Advance Directive is a written instruction recognized by state law, relating to the provisions of health care when the individual is incapacitated. - Upon admission, the resident or representative is provided written information concerning their rights under state law to make decisions concerning medical care. - Upon admission the IDT assesses the resident's decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity. - If the resident is incapacitated and unable to receive information about their right to formulate an advance directive, the information may be provided to the resident's legal representative.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain privacy of confidential information for two of four sampled residents (Resident 46 and 7), when Licensed Vocational Nurse (LVN) 3 left the residents' electronic health record (EHR- a digital version of a resident's paper chart) open and unattended. This deficient practice violated Resident 7 and 46's right to privacy and confidentiality of medical records. Findings: a. During a review of Resident 46's admission Record, the admission Record indicated that the facility originally admitted Resident 46 on 2/23/2024 and readmitted on [DATE] with diagnoses including unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and unspecified mood disorder (mental disorders characterized by a disturbance in mood which is abnormally depressed or elated). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 5/31/2026, the MDS indicated that the resident had severely impaired cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses). The MDS further indicated that Resident 46 required partial/moderate assistance (helper does less than half the effort) from staff for oral hygiene, toileting hygiene, upper and lower body dressing and substantial/maximal assistance (helper does more than half the effort) with personal hygiene. During a medication pass observation on 6/16/2026 at 3:57 p.m., observed LVN 3 step away and left the medication cart in the hallway with the laptop computer screen open on top of the medication cart. The computer screen displayed Resident 46's medication information and was visible while in the hallway while LVN 3 was in the resident's room administering medication. b. During a review of Resident 7's admission Record, the admission Record indicated that the facility originally admitted Resident 7 on 6/25/2018 and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms) and seizure (a sudden, uncontrolled surge of electrical activity in the brain). During a review of Resident 7's MDS, dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDS further indicated that Resident 7 was totally dependent (helper does all the effort) on staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a medication pass observation on 6/16/2026 at 4:22 p.m., observed LVN 3 step away and left the medication cart in the hallway with the laptop computer screen open on top of the medication cart. The computer screen displayed Resident 7's medication information and was visible while in the hallway while LVN 3 was in the resident's room administering medication. During an interview on 6/16/2026 at 4:25 p.m. with LVN 3, LVN 3 stated that she should not have left the computer screen open and visible in the hallway while she was in the Resident 46 and 7's room to administer medication. LVN 3 stated that leaving the computer screen open and with the resident's information visible is a violation of the resident's right to privacy of their medical records. During an interview on 6/18/2026 at 2:30 p.m. with the Director of Nursing (DON), the DON stated that residents have the right to privacy of their medical records. The DON stated that LVN 3 should have closed her computer while she was in the resident's room to ensure no unauthorized persons can view or access a resident's medical records to protect their identity and privacy and in keeping with their policy on HIPAA (Health Insurance Portability and Accountability Act - a U.S. federal law designed to keep your personal medical information private and secure). During a review of the facility's policy and procedure (P&P) titled, The Health Insurance Portability and Accountability Act (HIPAA), last (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity, including the right to be free from physical restraint (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one of two sampled residents (Resident 51) when staff did not remove the restraint as directed by the physician's order and care plan. This failure had the potential to increase the risk of harm including decreased circulation, skin breakdown, and decline in mobility. Finding: During a review of Resident 51's Face Sheet (admission Record), the Face Sheet indicated Resident 51 was admitted to the facility on [DATE] with diagnoses including but not limited to Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a disease characterized by a progressive decline in mental abilities), and major depressive disorder (constant feeling of sadness). During a review of Resident 51's History and Physical Examination (HP, a comprehensive physician's note regarding the assessment of the resident's health status) signed by the attending physician on 4/1/2026, the HP indicated Resident 51 does not have the capacity to understand and make decisions. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool), dated 4/17/2026, the MDS indicated Resident 51 cognitive ability is moderately impaired (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 51 require maximum assist (helper dose more than half of the effort) for sit to lying, lying to sitting, sit to stand, chair/bed transfer, toilet transfer). The MDS indicated Resident 51 has a trunk restraint. During a review of Resident 51's Physician Order Summary Report active orders, as of dated 6/16/2026, the Order Summary Report indicated an order dated 8/2/2025 for the following: - Support and safety device - Non-Self Release Belt (NSRB: Soft belt) while in wheelchair for safety secondary to resident continuously attempts to up/slide down and out of the wheelchair unassisted get due to Parkinson's disease and dementia. - Support and safety device-Release restrain every 2 hours for Activities of Daily Living (ADL- activities such as bathing, dressing and toileting a person performs daily), activities, and mealtime. During a review of Resident 51 Care Plan for Focus on Support & Safety device, initiated 5/6/2026, the care plan indicated release restraint every two (2) hours for ADL care, activities and mealtimes. The care plan goal indicated will minimize injury from the use of restraint and will minimize any complication from the use of restraint. During an observation on 6/15/2026 at 1:21 p.m. in the hallway in front of Resident 51 room, Resident 51 was seated in his wheelchair with NSRB fastened around his waist and the wheelchair. Observed Certified Nursing Assistant (CNA) 1 feeding Resident 51. Resident 51 was calm with no agitation while eating a meal. The clasp of the gait belt was fastened behind the back of the wheelchair. During a concurrent observation and interview on 6/15/2026 at 1:26 p.m. with Licensed Vocational Nurse (LVN) 2 in the hallway, Resident 51 was seated in his wheelchair with NSRB fastened around his waist and the wheelchair. Observed CNA 1 feeding Resident 51. Resident 51 was calm, with no agitation while eating a meal. LVN 2 stated Resident 51 was seated in his wheelchair with NSDR around his waist and the wheelchair. LVN 2 stated there is a physician order to remove the NSRB during mealtime, the NSRB should be removed based on physician orders during mealtime. LVN 2 stated there is a risk of harm such as preventing circulation and violating residents' rights. During an interview on 6/15/2026 at 1:34 p.m. with CNA 1, CNA 1 stated she was supposed to remove the NSRB during mealtime, (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however, she forgot. CNA 1 stated the NSRB is a restraint which restricts Resident 5 movement. During a concurrent interview and record review on 6/17/2026 at 8:34 a.m. with the Director of Nursing (DON), Resident 51's Order Summary Report, active orders as of dated 6/16/2026 with order dated 8/2/2025, were reviewed. The DON stated the Order Summary Report indicated an order for NSRB, while in wheelchair for safety secondary to resident continuously attempts to up/slide down and out of the wheelchair unassisted due to Parkinson's disease and dementia. The Order Summary Report indicated an order to release restraint every 2 hours for ADL, activities, and mealtime. The DON stated the NSRB is considered a restraint and based on the physician order, it should be released during mealtime to minimize injury from the use of restraints. During a concurrent interview and record review on 6/17/2026 at 8:38 a.m. with the DON, Resident 51's care plan on support & safety device, initiated 5/6/2026, was reviewed. The care plan indicated to release restraint every 2 hours for ADL care, activities and mealtimes with a goal to minimize injury from the use of restraint and will minimize any complication from the use of restraint. The DON stated care is developed to provide guidance for staff to provide necessary care for Resident 51. The DON stated the care plan was not followed. During a review of the facility's policy and procedure (P&P) titled, Residents Right, last reviewed on 4/15/2026, the P&P indicated "Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms. During a review of the P&P titled, Medication and treatment Administration, last reviewed on 4/15/2026, the P&P indicated "medication and treatment shall be administered as prescribed. During a review of the P&P titled, Policy: Physical Restraint, last revised on 4/14/2026, the P&P indicated physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, and which restrict freedom of movement or normal access to the use of one's body. The P&P indicated the Plan of Care shall specify the reason for the use of the restraint, the type, when and where it is to be used. During a review of the P&P titled, Care Plans, Comprehensive Person-Centered, last revised on 4/14/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five (5) sampled residents (Resident 69's) diagnosis of Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) was reflected in the resident's list of active diagnoses in the Minimum Data Set (MDS - a resident assessment tool). This failure resulted in Resident 69 having an inaccurate MDS assessment. Findings: During a review of Resident 69's Face Sheet (admission Record), the Face Sheet indicated the facility admitted the resident on 12/30/2020 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), schizophrenia (a mental illness that is characterized by disturbances in thought), and major depressive disorder recurrent (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 69's History and Physical Examination (HP, a comprehensive physician's note regarding the assessment of the resident's health status), signed by the attending physician on 5/6/2026, the HP indicated Resident 69 does not have the capacity to understand and make decisions. During a review of Resident 69's MDS, dated [DATE], the MDS indicated Resident 69's cognition (can think, learn, remember, use judgement, and make decisions) was severely impaired. The MDS did not indicate Resident 69 had depression under the Active Diagnoses section. During a review of Resident 69's psychiatric progress note, dated 2/23/2026, the psychiatric progress note documented that Resident 69's chief complaint included depression, emotional mood swings, and neurocognitive impairment. The psychiatric progress note indicated diagnoses of schizophrenia and major depressive disorder. During a review of Resident 69's psychiatric progress note, dated 4/29/2026, the psychiatric progress note documented that Resident 69's chief complaint included depression, emotional mood swings, and neurocognitive impairment. The psychiatric progress note indicated diagnoses of schizophrenia and major depressive disorder. During a concurrent interview and record review on 6/16/2026 at 3:26 p.m. with Minimum Data Set Coordinator (MDSC) 1, Resident 69's MDS, dated [DATE], was reviewed. MDSC 1 stated Resident 69's MDS did not indicate a diagnosis of depression under the Active Diagnoses section despite being included in Face Sheet. MDSC 1 stated the diagnosis of depression should be in the MDS because Resident 69 has diagnoses of depression. During a concurrent interview and record review on 6/17/2026 at 8:38 a.m. with the Director of Nursing (DON), Resident 69's Face Sheet was reviewed. The DON stated there is a diagnosis of Depression listed on the resident's Face Sheet. The DON stated the Face Sheet is accurate. During a concurrent interview and record review on 6/17/2026 at 8:40 a.m. with the DON, Resident 69's MDS, dated [DATE], was reviewed. The DON stated the MDS did not indicate a diagnosis of depression under the Active Diagnoses section despite being included in Face Sheet. The DON stated Resident 69's MDS should include the diagnosis of depression so that the assessment contains all necessary information so that the care plan includes appropriate monitoring of the resident's behavior, and because CMS (Centers for Medicare & Medicaid Services) requires facilities to report all active diagnoses on the MDS. The DON stated the MDS is not accurately coded. During a review of the facility's policy and procedure (P&P) titled, MDS Assessment Coordinator, last reviewed on 4/15/2026, the P&P indicated each individual who completes a portion of the assessment MDS must certify the accuracy of that each portion of the assessment by dating and signing the assessment and identifying each section completed.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to follow-up with the Preadmission Screening and Resident Review (PASRR) a mandatory federal program requiring all applicants to Medicaid-certified nursing facilities to be screened for serious mental illness (SMI) or intellectual disability (ID/DD) to obtain a PASRR Level II evaluation (an in-depth, mandatory assessment conducted when a Level I screen indicates a potential SMI, ID/DD, or related condition (RC)) for one of five sampled residents (Resident 8). This deficient practice had the potential to result in inappropriate placement and unidentified specialized services needs for Resident 8. Findings: During a review of Resident 8's admission Record, the admission Record indicated the facility originally admitted Resident 8 on 12/8/2020 and readmitted Resident 8 on 11/22/2022 with diagnoses that included unspecified 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 8's History and Physical (H&P - is the most formal and complete assessment of the resident and the problem), dated 4/21/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated Resident 8's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience and the senses) was moderately impaired. The MDS indicated Resident 8 required supervision or touching assistance (helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff with eating, oral hygiene, toileting hygiene, shower/bathe self, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 8's PASRR Level I screening, dated 11/22/2022, the PASRR Level I indicated that Resident 8 has a serious diagnosed mental disorder (schizoaffective). During a concurrent interview and record review on 6/16/2026 at 3:11 p.m. with the Director of Nursing (DON), Resident 8's PASRR Level I and a letter from Department of Health Care Services (DHCS) letter, dated 12/6/2022, were reviewed. The DON stated that the result of the PASRR Level I screening indicated that the resident had a diagnosis of schizoaffective disorder. The DON stated that the DHCS letter of 12/6/2022 indicated that the department was not able to complete the PASRR Level II because at that time the resident was isolated as a health or safety precaution. The DON stated that it was the time wherein multiple residents were in isolation due to the COVID-19 pandemic. The DON stated that after the period of isolation, the facility should have resubmitted a new PASRR Level I screen and request for a PASRR Level II evaluation. The DON stated that they missed conducting a new PASRR Level I screen for Resident 8. The DON stated that it is important for the PASRR Level II screen to be completed and ensure the resident will be placed in an appropriate setting and if any specialized services are needed. During a review of the facility's policy and procedure (P&P) titled, Pre-admission Screening Level Resident Review (PASARR), last reviewed 4/15/2026, the P&P indicated the policy's purpose is To ensure each resident with serious mental illness (SMI) and/or intellectual developmental disability/related to conditions (ID/DD/RC) will have the appropriate setting, as well as if any specialized services and/or rehabilitative services would be needed.the facility's designated staff will review the available information from the PASRR Online System regularly, follow up with the DHCS/DDS contractor on Level II determination/recommendation, and document and maintain records.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow facility policy for gastrostomy tube (G-Tube - a plastic tube inserted into the stomach to administer medications and food) medication administration when Licensed Vocational Nurse (LVN) 1 was observed giving a resident medications by slow push (a method to give medications by slowly depressing a syringe plunger by hand) and not by gravity (giving medications by pouring medications into a syringe, and letting gravity pull the liquid into the stomach) for one of nine residents (Resident 11) observed during the medication administration observation. This had the potential for nausea, vomiting, or cramping when given by slow push. Findings: During a review of Resident 11's Face Sheet (or admission record, the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility admitted the resident on 8/29/2020 and re-admitted on [DATE] with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 5/13/2026, the MDS indicated Resident 11 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 11 has a G-Tube. During a review of Resident 11's Physician's Orders, the orders indicated the following: - Enteral Feed (feeding through the stomach) order as needed, may slow push meds [medications] and fluids via G-Tube as needed if not contraindicated, dated 10/11/2025. - Enteral Feed Order, every shift, may crush all crushable medications and administer via G-Tube, dated 10/11/2025. - Acetaminophen (medication used to treat pain) Liquid 160 milligrams per five (5) milliliters (mg/ml, a metric unit of measurement, used for medication dosage and/or amount) give 20 ml via G-Tube two times a day for pain management related to osteoarthritis, dated 10/11/2025. - Metoprolol Tartrate (medication used to treat high blood pressure) Oral Tablet, give 12.5 mg enterally twice a day with feeding for congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), hold for systolic blood pressure (the top number in a blood pressure reading measuring the maximum pressure exerted on artery walls when the heart beats) is less than (<) 110 millimeters of mercury (mm Hg, a unit of measure for blood pressure) or heart rate < 60 beats per minute, dated 10/11/2025. During a review of Resident 11's Care Plan for Skin Integrity Impairment, initiated 9/12/2025, the care plan indicated Resident 11 was at risk for skin integrity impairment and potential for infection manifested by G-Tube wound site. The care plan indicated an intervention to administer medication as ordered. During a medication administration observation with LVN 1 on 6/16/2026 at 4:32 p.m., observed LVN 1 administering medications to Resident 11 through her G-Tube. Observed two medications administered, acetaminophen and metoprolol, with each one being given by a slow push method. When asked what the facility's policy is regarding slow push vs. gravity method, LVN 1 stated she did the slow push so that she would not mix the medications. LVN 1 stated she is fairly new and can get the answer from the Director of Nursing (DON). During a concurrent interview and record review with the DON on 6/17/2026 at 10:19 a.m., the DON reviewed the facility's policy and procedure titled, Administering Medications through an Enteral Tube, last reviewed 4/15/2026. The DON stated the policy indicates for a licensed nurse to administer each medication separately by (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gravity flow and may gently push if necessary. The DON stated LVN 1 should have followed the policy by at least trying to administer the medications by gravity first, and then if there was resistance to then conduct a slow push. The DON stated if necessary in the policy meant if there is resistance to medications going in by gravity or if the resident was anxious and the licensed nurse needed to administer medications faster than waiting for gravity to work. The DON stated this is important to prevent a faster accumulation of medication into the stomach. During a review of the facility's policy and procedure titled, Administering Medications through an Enteral Tube, last reviewed 4/15/2026, the policy indicated the following: - Administer each medication separately by gravity flow: a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion. b. Open the clamp and deliver medication slowly. May gently push if necessary.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Ensure Resident 46's Depakote (also known as divalproex sodium, medication primarily used to treat certain types of seizures [epilepsy], prevent migraine headaches, and manage manic or mixed episodes associated with bipolar disorder [a mental health condition that causes extreme, cyclical shifts in mood, energy, activity levels, and concentration]) Oral Tablet Delayed Release 125 milligram (mg - a unit of measure for mass) was administered as a whole tablet and not crushed. 2. Ensure Resident 7's medications Buspirone HCL (medication used to treat certain anxiety disorders or to relieve the symptoms of anxiety) Oral 2.5 mg tablet, Keppra (also known as levetiracetam, a medication used alone or together with other medicines to help control certain types of seizures) Oral Tablet 1000 mg, and Sinemet (a combination medication of carbidopa and levodopa used to treat symptoms of Parkinson's disease [a progressive nervous system disorder that affects movement]) 10-100 mg were administered as whole tablets and not crushed. This deficient practice had the potential to place two of 10 sampled residents (Resident 46 and 7) observed during medication administration at increased risk for stomach irritation and toxic side effect due to overdosing when the drugs are no longer released and absorbed gradually. Cross-reference F759. Findings: a. During a review of Resident 46's admission Record, the admission Record indicated that the facility originally admitted Resident 46 on 2/23/2024 and readmitted on [DATE] with diagnoses including unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and unspecified mood disorder (mental disorders characterized by a disturbance in mood which is abnormally depressed or elated). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 5/31/2026, the MDS indicated that the resident had severely impaired cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses). The MDS further indicated that Resident 46 required partial/moderate assistance (helper does less than half the effort) from staff for oral hygiene, toileting hygiene, upper and lower body dressing and substantial/maximal assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 46's Physician's Orders (PO), dated 5/20/2026, the PO indicated an order for Depakote Oral Tablet Delayed Release 125 mg, give one (1) tablet by mouth two times a day for mood disorder m/b uncontrollable mood swings causing anger interfering with activities of daily living. DO NOT CRUSH and give with food. During a medication pass observation on 6/16/2026 at 3:57 p.m., in Resident 46's door, by the hallway, observed Licensed Vocational Nurse (LVN) 3 preparing to administer medications to Resident 46. After verifying the medications that are due for administration from Resident 46's electronic chart, LVN 3 proceeded to take out the medication from the bubble pack (a blister pack, a method of packaging pills into individual, sealed compartments) of Depakote Oral Tablet Delayed Release 125 mg. LVN 3 then crushed the Depakote Oral Tablet Delayed Release and mixed it with apple sauce then administered the medication to Resident 46. b. During a review of Resident 7's admission Record, the admission Record indicated that the facility originally admitted Resident 7 on 6/25/2018 and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms) and seizure (a sudden, uncontrolled surge of electrical activity in the brain). During a review of Resident 7's MDS, dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDS further indicated that (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 7 was totally dependent (helper does all the effort) on staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 7's PO, the PO indicated an order for the following: - Buspirone HCL Oral Tablet 2.5 mg tablet by mouth three times a day dated 8/27/2025; - Keppra Oral Tablet 1000 mg, 1 tablet by mouth two times a day dated 1/6/2025; - Sinemet 10-100 mg, give 1 tablet by mouth before meals twice a day dated 1/06/2025. During a medication pass observation on 6/16/2026 at 4:22 p.m., in Resident 7's door, by the hallway, observed LVN 3 preparing to administer medications to Resident 7. After verifying the medications that are due for administration from Resident 7's electronic chart, LVN 3 proceeded to take out the medications from the bubble packs of Buspirone HCL Oral Tablet 2.5 mg, Keppra Oral Tablet 1000 mg, and Sinemet 10-100 mg. LVN 3 crushed the medications and placed the medications on a separate medication cups then mixed them with apple sauce and administered the medications using a spoon. During an interview after the medication pass observation on 6/16/2026 at 4:25 p.m., upon verifying with LVN 3 if the medication orders included a direction to crush the medications of Resident 46 and 7, LVN 3 stated that there is no direction to crush the medications. LVN 3 stated that during her (LVN 3) training, she (LVN 3) observed the nurses crush Resident 46 and 7's medications to prevent choking that's why she (LVN 3) also crushed them. LVN 3 stated that she (LVN 3) should have confirmed with the provider if the medications can be crushed for resident's safety. LVN 3 stated that the efficacy of the medications can be affected if they are crushed instead of administering them as a whole tablet due to different absorption time. LVN 3 stated that she (LVN 3) was not following the doctor's order in this case since there was no direction to crush the medications. During an interview on 6/18/2026 at 1:55 p.m., with the Director of Nursing (DON), the DON stated that the nurses should follow what is in the order and not to crush a medication that there is no direction to crush. The DON stated that for the Depakote Delayed Release tablet, it must not be crushed because it can cause irritation to the stomach and can potentially cause stomach bleeding. The DON stated that the Buspirone, Keppra and Sinemet are to be taken as a whole tablet since there is no direction to crush the medications to maintain its efficacy. During a review of the facility's policy and procedure (P&P) titled Administering Medications, last reviewed on 4/15/2026, the P&P indicated that Medications are administered in a safe and timely manner, and as prescribed.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 facility failed to ensure the Consultant Pharmacist's (CP) Medication Regimen Review (MRR - a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication) recommendation to consider a dose reduction, if appropriate, for Seroquel (also known as quetiapine, a medication used to treat certain mental/mood disorders) and Lexapro (also known as escitalopram, medication used to treat depression [mood disorder that causes a persistent, heavy feeling of sadness and a loss of interest in things you usually enjoy] and anxiety [mental health condition that involves excessive fear, worry, or nervousness that interferes with daily life]) for one of five residents (Resident 13) reviewed for Unnecessary Medications. This deficient practice placed the resident at increased risk for adverse effect of higher doses of Seroquel and Lexapro, such as heart rhythm issues which can lead to life-threatening arrhythmias (an irregular, too-fast, or too-slow heartbeat caused by a malfunction in the heart's electrical system) and Orthostatic Hypotension (a dangerous drop in blood pressure when standing up too quickly, which can lead to dizziness, fainting, and falls). Findings: During a review of Resident 13's admission Record (AR), the AR indicated that the facility originally admitted the resident on 3/21/2018 and readmitted on [DATE], with diagnoses including muscle weakness and paranoid schizophrenia (a severe mental health disorder where individuals experience intense paranoia, delusions, and auditory hallucinations). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 5/8/2026, the MDS indicated Resident 13 had the ability to sometimes makes self-understood and had the ability to sometimes understand others. The MDS indicated that the resident required substantial/maximal assistance (helper does more than half the effort) with oral hygiene, toileting hygiene, lower body dressing and partial/moderate assistance helper does less than half the effort) with upper body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review on 6/18/2026 at 11 a.m. with the Director of Nursing (DON), the CP's recommendations for Resident 13 for January and February 2026 and Resident 13's electronic Medication Administration Record (eMAR- the digital equivalent of traditional paper records used by healthcare professionals to track, document, and manage resident medications) were reviewed. The CP's recommendations for February and March 2026 indicated: - On 1/30/2026, the CP recommended to consider dose reduction of Seroquel 50 milligrams (mg - a unit of measure for mass) at hours of sleep (QHS) which the resident was taking since 9/22/2025; - On 2/28/2026, the CP recommended to consider dose reduction of Lexapro 10 mg once a day (QD) which the resident was taking since 8/22/2025. Resident 13's eMAR indicated: - For February 1 to 28, 2026, Seroquel 50 mg, one (1) tablet by mouth at bedtime was administered the entire month. - For March 1 to 31, 2026, Seroquel 50 mg, 1 tablet by mouth at bedtime was administered the entire month, - For March 1 to 31, 2026, Lexapro 10 mg, 1 tablet by mouth one time a day was administered the entire month. The DON stated the MRR is conducted every month and the objective is to determine if the medication is appropriate for the resident's condition/diagnosis, has an appropriate duration, and has any potential drug to drug interaction and side effects. The DON stated that if a resident is on a psychoactive or psychotropic medication (that changes brain function, altering your mood, perception, thoughts, or behavior), the review will include if a gradual dose reduction (GDR) is appropriate and if any laboratory blood works are to be monitored. The DON stated psychoactive or psychotropic medications can impair the (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident`s function and prolonging the use of Seroquel and Lexapro can result in adverse side effects. The DON stated that for these two months of medication regimen review (January and February 2026), the recommendation for a dose reduction was not communicated to the resident`s physician and no attempt at dose reduction was conducted per CP recommendation. The DON stated that the resident could unnecessarily experience adverse effects of the higher dose of these medications and a dose reduction can minimize the risks of the adverse effects. During a review of the facility`s policy and procedures (P&P) titled Medication Regimen Reviews, last reviewed on 4/15/2026, the P&P indicated A licensed Pharmacist reviews the medication regimen of each resident at least monthly.the purpose of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. During a review of the facility`s P&P titled Psychotherapeutic Medications, last reviewed on 4/15/2026, the P&P indicated that GDR will be attempted during at least two quarters during the first year unless clinically contraindicated.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 30 total opportunities contributed to an overall medication error rate of 13.33% affecting two of 10 residents (Resident 46 and 7) observed for medication administration. The medication errors were as follows: 1. The facility failed to ensure Resident 46's Depakote (also known as as divalproex sodium - medication primarily used to treat certain types of seizures [epilepsy], prevent migraine headaches, and manage manic or mixed episodes associated with bipolar disorder [a mental health condition that causes extreme, cyclical shifts in mood, energy, activity levels, and concentration]) Oral Tablet Delayed Release 125 milligram (mg - a unit of measurement for mass) was administered as a whole tablet and not crushed. 2. The facility failed to ensure Resident 7's medications Buspirone HCL (medication used to treat certain anxiety disorders or to relieve the symptoms of anxiety) Oral 2.5 mg tablet, Keppra (also known as levetiracetam, a medication used alone or together with other medicines to help control certain types of seizures) Oral Tablet 1000 mg, and Sinemet (a combination medication of carbidopa and levodopa used to treat symptoms of Parkinson's disease [a progressive nervous system disorder that affects movement]) 10-100 mg were administered as whole tablets and not crushed. These failures had the potential to result in Resident 46 and 7 receiving suboptimal (less than standard) care, experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that medication may have) and resulting in Residents 46 and 7's health and well-being negatively impacted. Cross-reference F755. Findings: a. During a review of Resident 46's admission Record, the admission Record indicated that the facility originally admitted Resident 46 on 2/23/2024 and readmitted on [DATE] with diagnoses including unspecified dementia (a condition in which a person loses the ability to think, remember, learn, make decisions, and solve problems) and unspecified mood disorder (mental disorders characterized by a disturbance in mood which is abnormally depressed or elated). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 5/31/2026, the MDS indicated that the resident had severely impaired cognition (the mental process of acquiring knowledge and understanding through thought, experience, and senses). The MDS further indicated that Resident 46 required partial/moderate assistance (helper does less than half the effort) from staff for oral hygiene, toileting hygiene, upper and lower body dressing and substantial/maximal assistance (helper does more than half the effort) with personal hygiene. During a review of Resident 46's Physician's Orders (PO), dated 5/20/2026, the PO indicated an order for Depakote Oral Tablet Delayed Release 125 mg, give one (1) tablet by mouth two times a day for mood disorder m/b uncontrollable mood swings causing anger interfering with activities of daily living. DO NOT CRUSH and give with food. During a medication pass observation on 6/16/2026 at 3:57 p.m., in Resident 46's door, by the hallway, observed Licensed Vocational Nurse (LVN) 3 preparing to administer medications to Resident 46. After verifying the medications that are due for administration from Resident 46's electronic chart, LVN 3 proceeded to take out the medication from the bubble pack (a blister pack, a method of packaging pills into individual, sealed compartments) of Depakote Oral Tablet Delayed Release 125 mg. LVN 3 then crushed the Depakote Oral Tablet Delayed Release and mixed it with apple sauce then administered the medication to Resident 46. b. During a review of Resident 7's admission Record, the admission Record indicated that the facility originally admitted Resident 7 on 6/25/2018 and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental health problem where you experience psychosis as well as mood symptoms) and (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	seizure (a sudden, uncontrolled surge of electrical activity in the brain). During a review of Resident 7's MDS, dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDS further indicated that Resident 7 was totally dependent (helper does all the effort) on staff for oral hygiene, toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 7's PO, the PO indicated an order for the following: -Buspirone HCL Oral Tablet 2.5 mg tablet by mouth three times a day dated 8/27/2025; -Keppra Oral Tablet 1000 mg, 1 tablet by mouth two times a day dated 1/6/2025; -Sinemet 10-100 mg, give 1 tablet by mouth before meals twice a day dated 1/06/2025. During a medication pass observation on 6/16/2026 at 4:22 p.m., in Resident 7's door, by the hallway, observed LVN 3 preparing to administer medications to Resident 7. After verifying the medications that are due for administration from Resident 7's electronic chart, LVN 3 proceeded to take out the medications from the bubble packs of Buspirone HCL Oral Tablet 2.5 mg, Keppra Oral Tablet 1000 mg, and Sinemet 10-100 mg. LVN 3 crushed the medications and placed the medications on a separate medication cups then mixed them with apple sauce and administered the medications using a spoon. During an interview after the medication pass observation on 6/16/2026 at 4:25 p.m., upon verifying with LVN 3 if the medication orders included a direction to crush the medications of Resident 46 and 7, LVN 3 stated that there is no direction to crush the medications. LVN 3 stated that during her (LVN 3) training, she (LVN 3) observed the nurses crush Resident 46 and 7's medications to prevent choking that's why she (LVN 3) also crushed them. LVN 3 stated that she (LVN 3) should have confirmed with the provider if the medications can be crushed for resident's safety. LVN 3 stated that the efficacy of the medications can be affected if they are crushed instead of administering them as a whole tablet due to different absorption time. LVN 3 stated that she (LVN 3) was not following the doctor's order in this case since there was no direction to crush the medications. During an interview on 6/18/2026 at 1:55 p.m., with the Director of Nursing (DON), the DON stated that the nurses should follow what is in the order and not to crush a medication that there is no direction to crush. The DON stated that for the Depakote Delayed Release tablet, it must not be crushed because it can cause irritation to the stomach and can potentially cause stomach bleeding. The DON stated that the Buspirone, Keppra and Sinemet are to be taken as a whole tablet since there is no direction to crush the medications to maintain its efficacy. During a review of the facility's policy and procedure (P&P) titled Administering Medications, last reviewed on 4/15/2026, the P&P indicated that Medications are administered in a safe and timely manner, and as prescribed.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an accurate and up-to-date Face Sheet (admission Record) for one (1) of 30 residents (Resident 3) reviewed for medical record accuracy when the facility staff did not remove an outdated diagnosis of dysphagia (difficulty swallowing) from Resident 3's Face Sheet. This failure had the potential to cause staff to implement unnecessary or inappropriate care interventions based on inaccurate clinical information. Findings: During a review of Resident 3's Face Sheet, the Face Sheet indicated the facility admitted the resident on 11/13/2025 and readmitted on [DATE] with diagnoses including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and dysphagia. During a review of Resident 3's History and Physical Examination (HP, a comprehensive physician's note regarding the assessment of the resident's health status) signed by the attending physician on 1/13/2026, the HP indicated Resident 3 does not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 5/15/2026, the MDS indicated the resident cognition (ability to think, learn, remember, use judgement, and make decisions) is severely impaired. The MDS did not indicate a diagnosis of dysphagia. During a review of Resident 3's Speech Therapy (ST) telephone order, dated 5/5/2026, the ST order indicated discontinue the medical diagnosis of dysphagia. During a concurrent interview and record review on 6/16/2026 at 4:10 p.m. with Minimum Data Set Coordinator (MDSC) 1, Resident 3's Face Sheet was reviewed. MDSC 1 stated Resident 3's Face Sheet indicated diagnosis of dysphagia; however, ST discontinued the dysphagia diagnosis on 5/5/2026. MDSC 1 stated the Face Sheet is not accurate and was not updated, which can lead to confusion for staff when providing care. During an interview on 6/17/2026 at 9:10 a.m. with the Director of Nursing (DON), the DON stated Resident 3's Face Sheet is not accurate since it includes a diagnosis of dysphagia that was discontinued on 5/5/2026 by the ST. The DON stated it is important to have update and accurate diagnosis to provide necessary care for residents. During an interview on 6/17/2026 at 11:01 a.m. with the ST, the ST stated Resident 3 does not have a diagnosis of dysphagia based on her assessment and Resident 3's dysphagia diagnosis was discontinued on 5/5/2026. During a review of the facility's policy and procedure (P&P) titled, Charting and Documentation, last reviewed on 4/15/2026, the P&P indicated the documentation in the medical record will be objective, complete, and accurate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: a. Ensure one (1) of 1 sampled resident (Resident 17) investigated under respiratory care nasal cannula (a medical device that delivers supplemental oxygen therapy to people with low oxygen levels) oxygen tubing was not touching the floor. This deficient practice had the potential to result in contamination of the resident's care equipment and risk of transmission of bacteria that can lead to infection. b. Report within 24 hours to the California Department of Public Health (CDPH) a resident with a new diagnosis of syphilis (a curable sexually transmitted infection caused by bacteria), which is a reportable disease (a disease that is to be appropriate county or health department officials) for one of three sampled (Resident 92) residents investigated for infection control. This deficient practice had the potential to place other residents at risk for spread of infection. Findings: a. During a review of Resident 17's admission Record (AR), the AR indicated the facility originally admitted the resident on 9/11/2024 and readmitted on [DATE] with diagnoses including acute respiratory failure (a sudden, life-threatening condition where the lungs fail to oxygenate the blood adequately) and shortness of breath (he uncomfortable feeling of not being able to catch your breath or get enough air into your lungs). During a review of Resident 17's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 6/2/2026, the MDS indicated the resident had the ability to sometimes makes self-understood and the ability to sometimes understand others. The MDS further indicated that Resident 17 required supervision or touching assistance (helper provide verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) from staff with oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on/taking off footwear and personal hygiene. During a review of Resident 17's Order Summary Report, dated 6/13/2026, the Order Summary Report indicated a physician's order to administer Oxygen at two (2) liters (a unit of measure for volume) per minute (LPM) via nasal cannula and may be titrated up to five (5) LPM for oxygen saturation (the amount of oxygen that's circulating in the blood) less than 92% every shift. During the initial tour observation on 6/15/2026 at 9:44 a.m., observed Resident 17 in his bed sleeping. The resident was connected to an oxygen concentrator via a nasal cannula tubing. The nasal cannula tubing formed a loop with the middle part of the nasal cannula tubing laying on the floor. During a concurrent observation and interview on 6/15/2026 at 10:30 a.m. with the Infection Preventionist Nurse (IPN) in Resident 17's room, observed the resident connected to an oxygen concentrator (a medical device that draws in ambient air, filters out nitrogen, and delivers concentrated oxygen (up to 95% pure) for residents requiring supplemental oxygen therapy) via a nasal cannula tubing that was forming a loop with the middle part touching the floor. The IPN stated that if the nasal cannula tubing is touching the floor, it can increase the risk of infection because the floor is dirty and can contaminate the tubing. The IPN stated that to prevent the tubing from touching the floor they will place portion of them length of the tubing in the plastic bag that is hanging in the oxygen (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator machine. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control, last revised 1/2026, the P&P indicated the facility has written policies and procedures in accordance with current infection control standards of practice based on recognized guidelines and the facility assessment. During a review of the Centers for Disease Control (CDC) source material titled, Guidelines for Environmental Infection Control in Health-Care Facilities, dated 2003, the source material indicated floors can become rapidly contaminated from airborne microorganisms and those transferred from shoes, equipment wheels, and body substances. b. During a review of Resident 92's AR, the AR indicated the facility admitted the resident on 1/26/2026 and re-admitted on [DATE] with diagnoses that included schizophrenia (a mental illness that is characterized by disturbances in thought) and syphilis. During a review of Resident 92's MDS, dated [DATE], the MDS indicated Resident 92 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 92 required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with eating. During a review of Resident 92's Physician's Orders, dated 6/9/2026, the physician's orders indicated an order for Doxycycline Hyclate Oral Tablet (a broad-spectrum antibiotic to treat bacterial infections) 100 milligrams (mg &ndash; a unit of measure for mass), give 1 tablet by mouth two times a day for syphilis for 30 days, give with a snack. During a review of Resident 92's Care Plan for Infection: Syphilis, initiated 6/9/2026, the care plan indicated a goal that Resident 92's infection will be resolved by the next assessment. The care plan indicated the following: - Administer antibiotic therapy as ordered, initiated 6/9/2026. - Follow up with CDPH regarding guidance and recommendations related to the resident with syphilis diagnosis. Will follow up with CDPH again in the morning, initiated 6/15/2026. - Followed up with general acute care hospital (GACH) for more information related to the resident's syphilis diagnosis. Will follow up with GACH infection manager again in the morning, initiated 6/15/2026. During a review of Resident 92's GACH Physician Progress Notes, dated 5/28/2026, the notes indicated the following: Resident 92 had a history of Rapid Plasma Reagin positive, ratio 1:1 (RPR, a test used to detect syphilis), and Fluorescent Treponemal Antibody-Absorption (FTA-ABS, a highly specific blood serum test used to detect antibodies targeting the bacteria that causes syphilis) positive test. We will check with Public Health regarding previous syphilis treatment; we (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will initiate treatment. During a review of Resident 92's GACH Laboratory Report, resulted 5/28/2026, the labs indicated Resident 92 had a positive RPR and FTA-ABS result. During a review of Resident 92's Sexually Transmitted Disease & Confidential Morbidity Report (an official, privacy-protected document used by healthcare providers to alert local or state public health departments about the diagnosis or suspicion of a reportable sexually transmitted disease), dated 6/16/2026, the report indicated the facility is reporting Resident 92 has syphilis to the County of Los Angeles Public Health department. During an interview with the Director of Nursing (DON) on 6/15/2026 at 3:45 p.m., the DON stated the facility did not report Resident 92's syphilis diagnosis to public health. The DON stated this is a new diagnosis and was discovered during Resident 92's last hospitalization. During a phone interview with the CDPH PHN on 6/16/2026 at 9:55 a.m., the CDPH PHN stated the facility is a mandated reporter (regarding an infection which is a legal obligation placed on healthcare providers to report specific, dangerous communicable diseases to local or state health authorities) because they are providing treatment for Resident 92. During a concurrent interview and record review with the IPN on 6/16/2026 at 1:45 p.m., the facility's P&P titled, Reportable Diseases, last reviewed 4/15/2026, was reviewed. The IPN stated Resident 92's Psychiatrist (PSYCH MD) called the GACH physician to find out more information. The IPN stated the GACH physician told the PSYCH MD that GACH did not report the case to public health but only inquired if he had been treated in the past. The IPN stated the facility is a mandated reporter because the facility is providing treatment. The IPN stated he should have reported Resident 92's syphilis diagnosis to the public health nurse within 24 hours according to the facility's policy. The IPN stated it is important to report timely to keep track of the infection and to follow any public health nurse recommendations to ensure other residents are not at risk for infection. During an interview with the DON on 6/18/2026 at 1 p.m., the DON stated the facility should have reported Resident 92's diagnosis of syphilis within the required 24-hour time frame. The DON stated this is important for infection control. During a review of the facility's P&P titled, Reportable Diseases, last reviewed 4/15/2026, the P&P indicated the following: - Reportable diseases are infections, illness or conditions with public health significance that must be reported to the local and/or state health department. - When a resident(s) presents with a suspected or confirmed infection, illness or condition that is reportable, the Infection Preventionist (or designee) notified the local health department within the required timeframe. The local health department will report to the state and/or provide further instructions for the facility. (continued on next page)		

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of County of Los Angeles Public Health document titled, Reportable Diseases and Conditions, last revised 9/19/2025, the document indicated syphilis is to be reported by electronic transmission, telephone, or mail within 1 working day from identification.		