STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555716	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing and Subacute	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on observation, interview and record review, the facility failed to: 1. Develop and implement a comprehensive person-centered care plan (CP, a plan for individual's specific health needs and desired health outcomes) with individualized oral care interventions for one of one sampled resident (Resident 67) with a tracheostomy (a surgical procedure to create an opening through the neck into the trachea [windpipe]) and dependent on ventilator (a medical device that helps a person breathe when they are unable to do so on their own) during a random observation. This deficient practice had the potential to cause health complications for Resident 67 due to inadequate oral hygiene. 2. Implement a care plan (CP- a plan for individual's specific health needs and desired health outcomes) intervention of providing a floor mat (padded mat placed on the floor to cushion falls and prevent injury) for one of one sampled resident (Resident 76) reviewed under the accidents care area. This deficient practice placed the resident at risk for injuries resulting from a fall. Findings: 1. During a review of Resident 67's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 6/4/2024 and readmitted on [DATE] with diagnoses including dysphagia(swallowing difficulties), encephalopathy (a group of conditions that cause brain dysfunction), and dependence on respirator [ventilator] status. During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/15/2025, the MDS indicated Resident 67 was rarely/never understood. The MDS indicated Resident 67 was dependent on staff for all activities such as hygiene, dressing, toileting, bathing and all movements such as rolling left to right. The MDS further indicated Resident 67 had continuous oxygen therapy through a mechanical ventilator and uses a feeding tube for nutrition. During an observation on 5/19/2025 at 1:23 pm in Resident 67's room, Resident 67 was lying in bed attached to a ventilator and feeding tube. Resident 67 was rubbing her lips with the back of her left hand. Resident 67 had very dry lips that were cracked with a thick layer of dry crust of saliva/skin on her lips. (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/19/2025 at 1:26 pm with RN 2 in Resident 67's room, RN 2 looked at Resident 67's lips and stated they looked very dry and needed oral care. RN 2 stated there is a potential for Resident 67's lips to bleed or have pain. During a concurrent interview and record review on 5/19/2025 at 2:32 pm with RN 2 of Resident 67's Care Plans, RN 2 stated she could not locate a care plan with an intervention to provide oral care for the resident. RN 2 stated without a care plan or intervention, staff will not know to provide oral care and Resident 67 had the potential for more build-up on her lips and even possibly an infection if the lips become cracked and bleed. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, last reviewed on 7/18/2024, the P&P indicated the purpose of the P&P was to provide individualized care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs for each resident. During a review of the facility's P&P titled, Activities of Daily Living (ADLs), Supporting last reviewed on 7/18/2024, the P&P indicated appropriate care, and services will be provided for residents who are unable to carry out ADLs independently such as oral care. During a review of the facility's P&P titled, Mouth Care last reviewed on 7/18/2024, indicated the purpose of the policy are to keep the resident's lips and oral tissues moist and to cleanse and freshen the resident's mouth and prevent oral infection. 2. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 5/1/2025 with diagnoses including acute (sudden) and chronic (long-lasting) respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues), malignant neoplasm (cancerous tumor) of the larynx (area of the throat known as the voice box), and dysphagia (swallowing difficulties During a review of Resident 76's History and Physical (H&P), dated 4/8/2025, the H&P indicated Resident 76 did not have the capacity to understand and make decisions. During a review of Resident 76's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 5/6/2025, the MDS indicated Resident 76 had the capacity to make himself understood and to understand others. The MDS indicated Resident 76 needed moderate assistance with activities such as oral hygiene and dressing and movements such as rolling left to right and sit to stand. During a review of Resident 76's Order Summary Report, the Order Summary Report indicated an order dated 5/19/2025 to provide Resident 76 with a floor mat on the left side of the bed for injury prevention. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/19/2025 at 1:40 pm in Resident 76's room, Resident 76 was found on the floor. Resident 76's left side of bed was pushed against the wall and Resident 76 was on the ground with his back against the right side of the bed and his feet out. This surveyor called out for assistance and Registered Nurse 2 (RN 2) and Licensed Vocational Nurse 1 (LVN 1) came into the room to assist and assess Resident 76. There was not a floor mat next to Resident 76's bed. Resident 76 was attached to a ventilator via tracheostomy (and opening created in the trachea (tube used for breathing connected to the lungs), enteral (form of nutrition that is delivered into the digestive system as a liquid usually by a gastrostomy tube [GT- a tube inserted into the stomach through a small opening in the abdomen to deliver nutrition, fluids and medications]) feeding via gastrostomy tube and urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). During a concurrent observation and interview on 5/19/2025 at 1:45 pm with RN 2 in Resident 76's room, RN 2 stated Resident 76 does not have a floor mat but should have one. During a concurrent interview and record review on 5/19/2025 at 2:15 pm with RN 2 of Resident 76's risk for fall care plan, RN 2 stated the care plan indicated an intervention to have a floor mat, if indicated. During a review of the facility's policy and procedure (P&P) titled, Care Plan Comprehensive, last reviewed on 7/18/2024, indicated the purpose of the P&P was to provide individualized care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs for each resident. The P&P further indicates assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the residents' conditions change. During a review of the facility's P&P titled, Falls - Clinical Protocol last reviewed on 7/18/2024, indicated residents should be assessed and risk factors such as medical conditions and weakness should be identified.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 50033 Based on observation, interview, and record review, the facility failed to ensure proper technique for administering medications through an enteral tube (a tube inserted into the gastrointestinal tract to deliver nutrition and medications) for one of two residents (Resident 74) observed during the medication administration task observation when: 1. Excess crushed tablets were left in the medication cup after the medication was administered. 2. The enteral tube was not flushed with the amount of water indicated in the physician's order between medications. These deficient practices had the potential to cause complications for Resident 74 including clogging the enteral tube and not receiving the full amount of medication as ordered. Findings: During a review of Resident 74's Admission Record, the Admission Record indicated the facility originally admitted the resident on 12/28/2024 and readmitted the resident on 5/6/2025 with diagnoses including but not limited to encephalopathy (any disease that alters brain function or structure) and respiratory failure. During a review of Resident 74's History and Physical (H&P), dated 5/8/2025, the H&P indicated Resident 74 did not have the capacity to understand and make decisions. The H&P further indicated Resident 74 had an enteral tube in place. During a review of Resident 74's Minimum Data Set (MDS - a resident assessment tool), dated 4/4/2025, the MDS indicated Resident 74 had severely impaired cognitive skills (the ability to think, learn, and remember clearly) for daily decision making and was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 74's Physicians Orders, the Physician's Orders indicated the following orders dated 5/6/2025: 1. Magnesium Oxide 400 milligram (mg) oral tablet: give one tablet via enteral tube one time a day for supplement. 2. Zinc 50 mg oral tablet: give one tablet via enteral tube one time a day for supplement. 3. May crush medications as appropriate. 4. Flush enteral tube with 15 milliliters (ml) of water in between each medication. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/20/2025 at 9:32 a.m. with Licensed Vocational Nurse 6 (LVN 6), LVN 6 crushed magnesium oxide and zinc tablets and put in separate medicine cups with a small amount of water. LVN 6 administered the magnesium oxide through Resident 74's enteral tube, then flushed with 10 ml of water, then administered the zinc. The medication cups containing the crushed magnesium oxide and zinc tablets both had crushed medication on the bottom and sides of the medication cups after administration. LVN 6 stated he should have flushed with 15 ml of water between medications because that is what is in the orders. LVN 6 stated the enteral tube could potentially become clogged if not flushed properly. LVN 6 stated the magnesium oxide and zinc are supplements and the resident should be administered the entire amount of the crushed tablets in the medication cups. During an interview on 5/23/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated when administering medications through an enteral tube, each medication should be flushed with the amount indicated in the order to ensure each medication is administered separately and fully pushed down the enteral tube to the stomach. The DON stated the entire crushed tablet should be administered to ensure the resident gets the full dose, otherwise the medication may not be as effective. During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Medication Administration, last reviewed 7/18/2024, the P&P indicated the facility assures safe and effective administration of enteral formulas and medications via enteral tubes. The P&P indicated a prescriber's order may be obtained specifying the amount of liquid to be used for the flushing and administration of medications. During a review of the facility's P&P titled, Medication Administration - General Guidelines, last reviewed 7/18/2024, the P&P indicated medications are administered in accordance with written orders of the attending physician.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain oral hygiene for one of one sampled resident (Resident 67), who is unable to carry out activities of daily living, when Resident 67's lips were dry, cracked and had a thick layer of dried saliva and skin on them. This deficient practice resulted in Resident 67 having poor oral hygiene and had the potential to negatively affect the residents' psychosocial wellbeing. Findings: During a review of Resident 67's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 6/4/2024 and readmitted on [DATE] with diagnoses including hemiplegia (one-sided muscle paralysis or weakness), respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (low levels of oxygen in your body tissues), dysphagia(swallowing difficulties) and dependence of respirator [ventilator] status (a machine that helps someone breathe when they are unable to breathe on their own, or when their breathing is inadequate). During a review of Resident 67's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/15/2025, the MDS indicated Resident 67 was rarely/never understood. The MDS indicated Resident 67 was dependent on staff for all activities such as hygiene, dressing, toileting, bathing and all movements such as rolling left to right. The MDS further indicated Resident 67 had continuous oxygen therapy through a mechanical ventilator (a medical device to help support or replace breathing) and uses a feeding tube for nutrition. During an observation on 5/19/2025 at 1:23 pm in Resident 67's room, Resident 67 was lying in bed attached to a ventilator and feeding tube. Resident 67 was rubbing her lips with the back of her left hand. Resident 67 had very dry lip that were cracked with a thick layer of dry crust of saliva/skin on her lips. During a concurrent observation and interview on 5/19/2025 at 1:26 pm with Registered Nurse 2 (RN 2) in Resident 67's room, RN 2 looked at Resident 67's lips and stated they looked very dry and needed oral care. RN 2 stated there is a potential for Resident 67's lips to bleed or have pain. RN 2 stated Resident 67 could feel embarrassed due to the thick layer of saliva and skin on her lips and could affect Resident 67's feelings. During a review of the facility's policy and procedure (P&P) titled, Dignity, last reviewed on 7/18/2024, indicated all residents 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. During a review of the facility's P&P titled, Activities of Daily Living (ADLs), Supporting last reviewed on 7/18/2024, indicated appropriate care and services will be provided for residents who are unable to carry out ADLs independently such as oral care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Mouth Care last reviewed on 7/18/2024, indicated the purpose of the policy are to keep the resident's lips and oral tissues moist and to cleanse and freshen the resident's mouth and prevent oral infection.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to provide an environment that is free from accident hazards for three of five sampled residents (Residents 37, 56, and 76) by: 1. Failing to ensure Residents 37 and 56 had siderails that were fully covered with padding as indicated per the resident's physician orders. 2. not providing a floor mat, not having curtains drawn back for ease of visibility and not having sufficient lighting for Resident 76. This deficient practice placed Resident 37, 56 and 76 at increased risk for injuries. Findings: 1.a. During a review of Resident 37's Admission Record, the Admission Record indicated the facility originally admitted the resident on 11/29/2022 and readmitted the resident on 4/15/2025 with diagnoses including but not limited to acute (severe, sudden onset) and chronic (long-term) respiratory failure (a condition where the lungs cannot get enough oxygen into your blood), cerebral infarction (an obstruction of blood flow in the brain that leads to tissue damage), and epileptic seizures (a sudden, temporary disruption in brain electrical activity that can cause involuntary changes in body movement, behavior, sensation, or awareness). During a review of Resident 37's History and Physical (H&P- a formal assessment by a healthcare provider that involves a resident interview, physical exam, and documentation of findings), dated 4/14/2025, the H&P indicated Resident 37 did not have the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool), dated 3/6/2025, the MDS indicated Resident 37 had severely impaired cognitive skills (the ability to think, learn, and remember clearly) for daily decision making and was dependent on staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS further indicated Resident 37 had a seizure disorder. During a review of Resident 37's physician orders, the physician orders indicated the following order dated 4/17/2025: Bilateral siderails with padding to prevent injury during episodes of seizure. During a review of Resident 37's care plan (a document that summarizes a resident's needs, goals, and care/treatment) titled, Bilateral 1/4 siderails with padding to prevent injury during episodes of seizure ., dated 12/1/2022, the care plan indicated the goal of the padded side rails is to ensure the resident is not injured during a seizure. During a review of Resident 37's care plan titled, Resident is at risk for injury related to diagnosis of seizure ., dated 4/29/2024, the care plan indicated a goal that the resident will be free of any seizure related injury with an intervention to maintain a safe environment. (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 observation on 5/22/2025 at 9:21 a.m., at Resident 37's bedside, observed Resident 37 in bed with the bed rails partially exposed. The bed rail padding had slipped down from both the right and left upper bed rails leaving the hard railing exposed. During a concurrent observation and interview on 5/22/2025 at 12:05 p.m., with Registered Nurse 1 (RN 1), observed Resident 37 in bed with the bed rails partially exposed. RN 1 stated the padding should cover the bedrails. RN 1 stated Resident 37 needs the padding to protect him from hitting the bed rail in case he has a seizure. 1.b. During a review of Resident 56's Admission Record, the Admission Record indicated the facility admitted the resident on 4/26/2024 with diagnoses including but not limited to anoxic brain damage (an injury to the brain from a lack of oxygen) and intractable epilepsy (a seizure disorder that cannot be fully managed with medications). During a review of Resident 56's H&P, dated 4/26/2025, the H&P indicated Resident 56 did not have the capacity to understand and make decisions. During a review of Resident 56's MDS, dated [DATE], the MDS indicated Resident 56 had severely impaired cognitive skills for daily decision making and was dependent on staff for all activities of daily living. The MDS further indicated Resident 56 had a seizure disorder. During a review of Resident 56's physician orders, the physician orders indicated the following order dated 4/26/2024: Bilateral padded siderails up and locked when in bed for seizure management. During a review of Resident 56's care plan titled, Resident has diagnosis of seizure disorder at risk for fall and injury ., dated 4/29/2024, the care plan indicated a goal that resident will be free of any seizure related injury with an intervention to maintain a safe environment. During a review of Resident 56's care plan titled, Bilateral padded bed rail ., dated 11/22/2024, the care plan indicated the goal to minimize episodes of accidents or incidents related to the use of side rail with the intervention to apply bilateral 1/4 rail as ordered and tolerated. During an observation on 5/22/2025 at 10:27 a.m., at Resident 56's bedside, observed Resident 56 in bed and the left upper side rail had no padding. During a concurrent observation and interview on 5/22/2025 at 11:54 a.m., with RN 1, observed Resident 56 in bed and the left upper side rail had no padding. RN 1 stated Resident 56 should have padded bed rails for seizure management. RN 1 stated Resident 56 needs the padding on the bed rails so she will be protected in case she has a seizure. During a review of the facility's policy and procedure (P&P) titled, Bed Safety, last reviewed 7/18/2024, the P&P indicated the facility will strive to prevent or reduce hazards associated with hospital beds when side rails are required. 49947 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 76's Admission Record, the Admission Record indicated the facility admitted Resident 76 on 5/1/2025 with diagnoses that included, but not limited acute and chronic respiratory failure with hypoxia (low levels of oxygen in your body tissues), malignant neoplasm (cancerous tumor) of the larynx (area of the throat known as the voice box), dysphagia (swallowing difficulties), and difficulty walking During a review of Resident 76's H&P, dated 4/8/2025, the H&P indicated Resident 76 did not have the capacity to understand and make decisions. During a review of Resident 76's MDS, dated [DATE], the MDS indicated Resident 76 had the capacity to make himself understood and to understand others. The MDS indicated Resident 76 needed moderate assistance with activities such as oral hygiene and dressing and movements such as rolling left to right and sit to stand. During a review of Resident 76's Resident is at Risk for Falls/Injury Due to Impaired Mobility Care Plan (CP), the CP indicated an intervention of a fall mat(s) if indicated. During a review of Resident 76's Order Summary Report, the Order Summary Report indicated an order dated 5/19/2025 to provide Resident 76 with a floor mat on the left side of the bed for injury prevention. During an observation on 5/19/2025 at 1:40 pm in Resident 76's room, Resident 76 was found on the floor. Resident 76's left side of bed was pushed against the wall and Resident 76 was on the ground with his back against the right side of the bed and his feet out. The lighting level was very low and Resident 76's curtain was drawn so this surveyor could not see that Resident 76 was on the floor until this surveyor walked several feet into the room. Resident 76 nor his bed was visible from the hallway. This surveyor called out for assistance and Resighted Nurse 2 (RN 2) and Licensed Vocational Nurse 1 (LVN 1) came into the room to assist and assess Resident 76. There was not a floor mat next to Resident 76's bed. Resident 76 was attached to a ventilator via tracheostomy (and opening created in the trachea (tube used for breathing connected to the lungs), enteral feeding via gastrostomy tube and urinary catheter. During a concurrent observation and interview on 5/19/2025 at 1:45 pm with RN 2 in Resident 76's room, RN 2 was assessing Resident 76 and stated Resident 76 did not have a floor mat but should have one. RN 2 further stated the curtains should have been drawn back for visibility and stated the room should have been better lit so the resident could see better. During a concurrent interview and record review on 5/19/2025 at 2:15pm with RN 2 of Resident 76's risk for fall care plan, RN 2 stated the care plan states as an intervention to have a floor mat, if indicated. RN 2 stated Resident 76 has been restless for a several days and there should have been a floor mat to prevent injuries. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed on 7/18/2024, indicated residents should be provided with a safe homelike environment and adequate lighting to promote safety. (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 P&P titled, Falls - Clinical Protocol last reviewed on 7/18/2024, indicated residents should be assessed and risk factors such as medical conditions and weakness should be identified.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49947 Based on observation, interview, and record review the facility failed to ensure a resident who was incontinent (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTIs, common infections that happen when bacteria infect the urinary tract) by failing to ensure the urinary catheter did not coil (unwanted twist or bend) or loop to one of one sampled residents (Resident 60) reviewed under the urinary catheter (a tube that is inserted into the bladder, allowing urine to drain) care area. This deficient practice had the increased potential for Resident 60 to obtain a UTI. Findings: During a review of Resident 60's Admission Record, the Admission Record indicated the facility admitted Resident 15 on 4/7/2025 with diagnoses including hemiplegia (a condition causing paralysis on one side of the body, often resulting from brain damage) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (disrupted blood flow to the brain, leading to tissue death), neuromuscular dysfunction of bladder (when a person lacks bladder control due to brain, spinal cord or nerve problems), and retention (abnormal keeping of fluids) of urine. During a review of Resident 60's Minimum Data Set (MDS - an assessment and care screening tool) dated 4/10/2025, the MDS indicated Resident 60 was at times confused and sometimes able to understand or be understood by others. The MDS indicated Resident 60 was dependent on staff for hygiene, dressing, toileting, bathing and movement such as walking, transfers, sit to stand are not attempted due to medical conditions or safety concerns. The MDS further indicated Resident 60 had a urinary catheter. During a review of Resident 60's Order Summary Report, the Order Summary Report indicated Resident 60's physician ordered an indwelling (inside the body) catheter for retention/neurogenic bladder on 5/8/2025. During a review of Resident 60's Interdisciplinary Progress Note dated 5/12/2025, the Progress Note indicated Resident 60 was admitted on [DATE] with a foley (urinary) catheter and had a UTI on 4/26/2025 and then again on 5/12/2025. During an observation on 5/20/2025 at 10:25 am in Resident 60's room, Resident 60 was lying in bed with a urinary catheter bag hanging on the right side of the resident's bedframe. The urinary catheter tubing hung below the middle-right side of the bed and had a long dependent loop and 2 coils - one of which was kinked. The looped and coiled portion of the urinary catheter tubing contained yellow liquid with white sediments. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing and Subacute	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview with the Minimum Data Set Coordinator (MDSC) on 5/20/2025 at 10:30 am in Resident 60's room, the MDSC looked at Resident 60's urinary catheter tubing and stated the tubing should not be looped and coiled like it was and hung towards the end of the bed and not the middle of the bed frame to prevent backflow or infection. The MDSC stated there was yellow liquid and white sediments in the tubing. During an interview on 5/20/2025 at 10:55 am with Registered Nurse 3 (RN 3), RN 3 stated staff should ensure the catheter tubing is straight to drain the urine into the urinary catheter bag. RN 3 further stated Resident 60 has a history of UTIs and his catheter tubing must not be coiled, looped or kinked to prevent back flow of urine into the body and to prevent another infection. During a review of the facility provided Policy and Procedure (P&P) titled, Urinary Tract Infections (Catheter Associated), Guidelines for Preventing last reviewed on 7/18/2024, the P&P indicated to maintain an unobstructed urine flow by keeping the catheter tubing free of kinks.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on interview and record review, the facility failed to ensure the hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) center completed a post-dialysis assessment (evaluation done after hemodialysis by the hemodialysis licensed nurses) by not ensuring the dialysis center recorded a resident's post dialysis weight (the weight after fluid is removed during the dialysis treatment) on 5/15/2025. This deficient practice had the potential for Resident 43 to have unidentified complications after dialysis treatment such as abnormal vital signs (pulse rate, temperature, respiration rate, and blood pressure, that indicate the state of a patient's essential body functions). Findings: During a review of Resident 43's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including end stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 43's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 2/28/2025, the MDS indicated Resident 43 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 43 was dependent on staff for dressing, toileting, and personal hygiene. The MDS indicated Resident 43 receives dialysis treatments. During a review of Resident 43's Care Plan for Dialysis, initiated 2/09/2024, the care plan indicated a goal that the resident will avoid fluid overload by the next review date. The care plan indicated an intervention that the pre- and post-dialysis weights are to be taken at the dialysis center. During a review of Resident 43's Dialysis Communication Record, dated 5/15/2025, the Dialysis Communication Record indicated there was a blank space for the post-dialysis weight. During a concurrent interview and record review with Registered Nurse 3 (RN 3) on 5/23/2025 at 9 a.m., reviewed Resident 43's Dialysis Communication Record for 5/15/2025. RN 3 verified that there was a no post-dialysis weight recorded by the dialysis center on 5/15/2025. RN 3 stated the licensed nurses should call the dialysis center if there is no post-dialysis weight recorded. RN 3 stated this is important to ensure the weights are accurate and that there is no significant weight loss. During a concurrent interview and record review with the Director of Nursing (DON) on 5/23/2025 at 9 a.m., reviewed Resident 43's Dialysis Communication Record for 5/15/2025. The DON verified there was no post-dialysis weight documented for 5/15/2025. The DON stated the licensed nurses should have called the dialysis center to find out what the weight was. The DON stated it is important to follow-up with the dialysis center to ensure the resident is stable. During a review of the facility's Policy and Procedure titled, Dialysis (Renal), Pre- and Post-Care, last reviewed 7/18/2024, indicated the following: (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The dialysis provider will communicate in writing to the facility any problems encountered while the resident was at the dialysis provider and any ongoing monitoring required. - The provider's dialysis nurse will be responsible for documentation of dialysis treatment. During a review of Licensed Nurses Competency Skills: Care for the Hemodialysis Patient, last reviewed on 7/18/2024, it indicated the following: Pre- and post-dialysis weight must be documented in the dialysis communication paper. If this is missed by dialysis center, the licensed nurse must call the dialysis center to immediately fax the completed paper to the facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34659 Based on observation, interview, and record review the facility failed to ensure a licensed nursing staff possessed the competency (a measurable pattern of knowledge, skills, abilities, behaviors that an individual needs to perform work roles successfully) necessary to follow a physician's order by failing to take a Resident 62's apical pulse (a pulse point on the chest that gives the most accurate reading of the heart rate taken with a stethoscope [a device to listen to the heartbeat]) before giving a heart medication for one (LVN 2) of four licensed nurses observed during the medication pass observation. This deficient practice had the potential to cause complications such as bradycardia (slow heart rate with less than 60 beats per minute [bpm.]) dizziness, and syncope (fainting). Cross referenc to F760 Findings: During a review of Resident 62's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow). During a review of Resident 62's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/18/2025, the MDS indicated Resident 62 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 62 was independent with eating and oral hygiene. The MDS indicated Resident 62 had atrial fibrillation. During a review of Resident 62's Physician's Orders the Physician's Orders indicated the following orders: 1. Flecainide Acetate oral tablet 50 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every 12 hours for irregular heartbeat; hold dose if apical pulse is less than (<) 60 bpm., dated 3/26/2025. 2. Metoprolol tablet 50 mg, give one tablet by mouth two times a day for hypertension, hold for systolic blood pressure (SBP, the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats) < 110 millimeters of Mercury (mm Hg, a unit of measure for blood pressure) or heart rate is less than 60 bpm, dated 3/03/2025. During a review of Resident 62's Nursing Progress Note, dated 5/21/2025 at 8:42 a.m., the note indicated LVN 2 took the apical pulse with stethoscope and was 73 bmp. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 3/2025, covering the dates 3/26/2025 to 3/31/2025, the MAR indicated Resident 62's apical pulse was not taken before the Flecainide tablet was administered to Resident 62. During a review of Resident 62's MAR for the month of 4/2025, covering the dates 4/01/2025 to 4/31/2025, the MAR indicated Resident 62's apical pulse was not taken before the Flecainide tablet was administered to Resident 62. During a review of Resident 62's MAR for the month of 5/2025, covering the dates 5/01/2025 to 5/19/2025, the MAR indicated Resident 62's apical pulse was not taken before the Flecainide tablet was administered to Resident 62. During a review of Resident 62's Care Plan (CP) for Cardiac Arrhythmia (irregular heart rate), initiated 4/03/2025, the CP indicated a goal that the resident will be free from irregular heart rhythms until the next review date. The care plan indicated the interventions to administer medications as ordered, and to assess and monitor vital signs as ordered. During a medication pass observation on 5/21/2025 at 8:20 a.m., observed LVN 2 take Resident 62's blood pressure and radial pulse (pulse taken by feeling the pulse on the radial artery, located on the thumb side of the wrist). Asked LVN 2 if there was anything else that needed to be checked. LVN 2 stated there was not anything else to be checked. Resident 62 took the Flecainide before the survey team could intervene. Asked LVN 2 regarding the apical pulse, LVN 2 stated there was no order to check the apical pulse. Resident 62 stated the Flecainide did not have any parameter check before taking the medication. Reviewed the order with LVN 2 on the orders due page on the electronic medical record with the medication highlighted in a yellow box, with the parameter listed indicating to hold the medication if the apical pulse was below 60 bpm. LVN 2 stated he overlooked the order on the computer. LVN 2 stated the computer system did not prompt him (LVN 2) to take an apical pulse before marking as completed. LVN 2 stated the licensed nurse who entered the order should have added the parameter in the computer to ask what the apical pulse is. LVN 2 stated if the parameter was in place the computer system would not let a licensed nurse mark the medication as being given unless one entered a value in the apical pulse area. LVN 2 stated he (LVN 2) has never taken an apical pulse for Resident 62, before administering Flecainide in the past. During an interview with the Director of Nurses (DON) on 5/21/2025 at 11:13 a.m., the DON stated they were reviewing Resident 62's orders yesterday on 5/20/2025 and noticed there was no parameter set in the computer set which would require a licensed nurse to enter an apical pulse before marking the medication as being given. The DON stated she added the parameter in the computer then, which would not allow the Flecainide to be marked as given until the apical pulse was taken and recorded in the space provided. The DON stated LVN 2 should have read and followed Resident 62's Physician's Order for Flecainide with the parameter that was displayed on the orders due page. During an interview with the facility Pharmacist Consultant (PC) on 5/21/2025 at 2:30 p.m., the PC stated he (PC) made a recommendation in the monthly pharmacy reviews for licensed nurses to take an apical pulse for Resident 62 before giving the Flecainide. The PC stated the Flecainide should not be given if the apical pulse is below 60 bpm. The PC stated he (PC) made the recommendation because he (PC) wanted to be cautious before giving the medication because Flecainide can lower heart rate. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the DON on 5/22/2025 at 10:51 a.m., reviewed Resident 62's MARS for 3/2025, 4/2025, and 5/2025, and Resident 62's Nursing Progress Note, dated 5/21/2025 at 8:42 a.m. The DON verified that LVN 2 gave the Flecainide but did not take an apical pulse twice in 3/2025, 17 times in 4/2025, and 11 times in 5/2025. The DON stated they had LVN 2 return after the Flecainide was given on 5/21/2025 to take Resident 62's apical pulse. The DON stated that was why there was a value indicated on 5/21/2025 for the 9 a.m. administration. The DON stated it was important to take an apical pulse since it is more accurate than a radial pulse. The DON stated it is important because a resident could suffer complications such as bradycardia, dizziness, and syncope. During a concurrent interview and record review with the Director of Staff Development (DSD) on 5/23/2025 at 2:30 p.m., reviewed LVN 2's competency skills on medication administration, dated 2/20/2025. The DSD stated that LVN 2 attended training on 2/20/2025 that covered various nursing procedures. A review of LVN 2's competency skills check list indicated LVN 2 passed competency on reading medication labels and instructions carefully. The DSD verified that LVN 2 passed the competency which indicated following parameters as seen in the description as notify the attending physician if antihypertensive medication is held below the blood pressure/pulse rate parameter and document in the computerized progress notes. The DSD stated this would also include the medication Flecainide. During a review of the facility's policy and procedure titled, Medication Administration - General Guidelines, last reviewed 7/18/2024, indicated medications are administered in accordance with written orders of the attending physician.

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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. 34659 Based on observation, interview, and record review, the facility failed to have the pharmacy exchange the emergency kit (e-Kit, a collection of medications that need to be given immediately such as pain or antibiotic medication) within 72 hours according to the facility's policy and procedure for two (Subacute Nursing Station, Skilled Nursing Facility Nursing Station) of two Medication Rooms. This had the potential for medications to not be available in emergency situations. Findings: During a review of Resident 145's Admission Record (front page of the chart that contains a summary of basic information about the resident), the Admission Record indicated the facility admitted the resident on 4/22/2025 with diagnoses that included sepsis (a life-threatening blood infection). During a review of Resident 145' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/8/2025, the MDS indicated Resident 145 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 6 was dependent on staff for oral hygiene, toileting, dressing, and personal hygiene. During a review of Resident 145's Physician's Orders, the Physician Orders indicated an order for Cefepime 2 grams intravenously (IV, fluids given directly into the blood stream), one time a day for CRKP to the urine until 5/19/2025, dated 5/16/2025 During a review of the Subacute Medication Room E-kit Pharmacy Log which indicated two quantities of the two Ceftazidime medication in the E-kit was removed for Resident 145 on 5/14/2025 at 9 p.m. During a medication room inspection of the Subacute Station Medication Room on 5/19/2025 at 10:40 a.m. with Registered Nurse 2 (RN 2), inspected the intravenous medication (medications given through a vein) emergency kit (E-kit, a container of essential medications readily available to treat emergencies when residents need immediate care). The E-kit Documentation indicated two vials of Ceftazidime (a type of antibiotic medication) was removed from the E-kit on 5/14/2025 at 9 p.m. RN 2 stated they will call the pharmacy to have them change the e-Kit because they need to be changed within 24 hours. RN 2 stated this was important to ensure the antibiotic medications are available because the antibiotic medications may need to be started immediately upon being ordered. RN 2 stated if a medication is not there, then treatment could be delayed and possibly harm a resident. During a medication room inspection for the Skilled Nursing Facility Medication Room on 5/19/2025 at 10:50 a.m., with the Assistant Director of Nurses (ADON), inspected the intravenous medications E-kit. Verified with the ADON that the E-kit did not have a red or yellow zip tie. The ADON stated a red zip tie would indicate that the E-Kit had not been opened, and a yellow zip tie would indicate that the E-kit had been opened. The ADON stated there should be a yellow zip on the E-kit because the red zip tie was removed. The ADON verified that there was no documentation that any medication had been removed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the ADON on 5/20/2025 at 8:33 a.m., he stated the Skilled Nursing Facility E-kit was opened but no medication had been removed. The ADON stated the process is that if an E-kit is opened, a yellow zip tie should be placed and licensed nursing staff should call the pharmacy right away to have the E-kit replaced. The ADON stated it is important to follow this process to make sure medications are available for residents who need them. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 5/21/2025 at 7:15 a.m., he stated Resident 145 had an order for Cefepime, not for Ceftazidime. LVN 4 stated the Ceftazidime was not removed. LVN 4 stated, upon further review, Resident 145 had received the Cefepime earlier that day in the General Acute Care Hospital (GACH, or simply hospital). LVN 4 stated he timed the medication to begin in the facility the following day and would be delivered from the pharmacy and would not need to be removed from the E-kit. LVN 4 stated he should have corrected the document to indicate the Ceftazidime was not removed from the Subacute E-kit. During a review of the facility's policy and procedure(P&P) titled, Emergency Pharmacy Service and Emergency Kits, last reviewed 7/18/2024, the P&P indicated the following: - When an emergency or stated dose of a medication is needed, the nurse unlocks the container and removes the required medication. After removing the medication, completed the emergency E-kit slip and re-seal the emergency supply. An entry is made in the emergency log book containing all required information. - As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the emergency drug supply by faxing a request utilizing the prescription refill sticker. - If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening.

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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** 34659 Based on observation, interview, and record review, the facility failed to ensure residents were free from any significant medication errors for one (Resident 62) of four residents observed during the medication pass observation. Licensed Vocational Nurse 2 (LVN 2) failed to check Resident 62's apical pulse (a pulse point on the chest that gives the most accurate reading of the heart rate taken with a stethoscope [a device to listen to the heartbeat]) before giving a heart medication. This deficient practice had the potential to cause complications such as bradycardia (slow heart rate with less than 60 beats per minute [bpm.]) dizziness, and syncope (fainting). Findings: During a review of Resident 62's Admission Record, the Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular, often rapid heart rate that causes poor blood flow). During a review of Resident 62's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/18/2025, the MDS indicated Resident 62 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 62 was independent with eating and oral hygiene. The MDS indicated Resident 62 had atrial fibrillation. During a review of Resident 62's Physician's Orders, the Physician's Orders indicated the following orders: 1. Flecainide Acetate oral tablet 50 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth every 12 hours for irregular heartbeat; hold dose if apical pulse is less than (<) 60 bpm., dated 3/26/2025. 2. Metoprolol tablet 50 mg, give one tablet by mouth two times a day for hypertension, hold for systolic blood pressure (SBP, the top number in a blood pressure reading, representing the pressure in the arteries when the heart beats) < 110 millimeters of Mercury (mm Hg, a unit of measure for blood pressure) or heart rate is less than 60 bpm, dated 3/03/2025. During a review of Resident 62's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 3/2025, covering the dates 3/26/2025 to 3/31/2025, the MAR indicated Resident 62's apical pulse was not taken before the Flecainide tablet was administered to Resident 62. During a review of Resident 62's MAR for the month of 4/2025, covering the dates 4/01/2025 to 4/31/2025, the MAR indicated Resident 62's apical pulse was not taken before the Flecainide tablet was administered to Resident 62. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62's MAR for the month of 5/2025, covering the dates 5/01/2025 to 5/19/2025, the MAR indicated Resident 62's apical pulse was not taken before the Flecainide tablet was administered to Resident 62. During a review of Resident 62's Care Plan (CP) for Cardiac Arrhythmia (irregular heart rate), initiated 4/03/2025, the CP indicated a goal that the resident will be free from irregular heart rhythms until the next review date. The care plan indicated the interventions to administer medications as ordered, and to assess and monitor vital signs as ordered. During a review of Resident 62's Nursing Progress Note, dated 5/21/2025 at 8:42 a.m., the note indicated LVN 2 took the apical pulse with stethoscope and was 73 bmp. During a medication pass observation on 5/21/2025 at 8:20 a.m., observed LVN 2 take Resident 62's blood pressure and radial pulse (pulse taken by feeling the pulse on the radial artery, located on the thumb side of the wrist). Asked LVN 2 if there was anything else that needed to be checked. LVN 2 stated there was not anything else to be checked. Resident 62 took the Flecainide before the survey team could intervene. Asked LVN 2 regarding the apical pulse, LVN 2 stated there was no order to check the apical pulse. Resident 62 stated the Flecainide did not have any parameter check before taking the medication. Reviewed the order with LVN 2 on the orders due page on the electronic medical record with the medication highlighted in a yellow box, with the parameter listed indicating to hold the medication if the apical pulse was below 60 bpm. LVN 2 stated he overlooked the order on the computer. LVN 2 stated the computer system did not prompt him (LVN 2) to take an apical pulse before marking as completed. LVN 2 stated the licensed nurse who entered the order should have added the parameter in the computer to ask what the apical pulse is. LVN 2 stated if the parameter was in place the computer system would not let a licensed nurse mark the medication as being given unless one entered a value in the apical pulse area. LVN 2 stated he (LVN 2) has never taken an apical pulse for Resident 62, before administering Flecainide in the past. During an interview with the Director of Nursing (DON) on 5/21/2025 at 11:13 a.m., the DON stated she (DON) was reviewing Resident 62's orders yesterday on 5/20/2025 and noticed there was no parameter set in the computer set which would require a licensed nurse to enter an apical pulse before marking the medication as being given. The DON stated she added the parameter in the computer then, which would not allow the flecainide to be marked as given until the apical pulse was taken and recorded in the space provided. During an interview with the facility Pharmacist Consultant (PC) on 5/21/2025 at 2:30 p.m., the PC stated he (PC) made a recommendation in the monthly pharmacy reviews for licensed nurses to take an apical pulse for Resident 62 before giving the Flecainide. The PC stated the Flecainide should not be given if the apical pulse is below 60 bpm. The PC stated he (PC) made the recommendation because he (PC) wanted to be cautious before giving the medication because Flecainide can lower heart rate. (continued on next page)

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	555716	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Nursing and Subacute	6740 Wilbur Ave Opco, LLC Reseda, CA 91335

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review with the DON on 5/22/2025 at 10:51 a.m., reviewed Resident 62's MARS for 3/2025, 4/2025, and 5/2025, and Resident 62's Nursing Progress Note, dated 5/21/2025 at 8:42 a.m. The DON verified that LVN 2 gave the Flecainide but did not take an apical pulse twice in 3/2025, 17 times in 4/2025, and 11 times in 5/2025. The DON stated they had LVN 2 return after the Flecainide was given on 5/21/2025 to take Resident 62's apical pulse. The DON stated that was why there was a value indicated on 5/21/2025 for the 9 a.m. administration. The DON stated it was important to take an apical pulse since it is more accurate than a radial pulse. The DON stated it is important because a resident could suffer complications such as bradycardia, dizziness, and syncope. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last reviewed 7/18/2024, the P&P indicated medications are administered in accordance with written orders of the attending physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50033 Based on observation, interview, and record review, the facility failed to ensure medication was properly stored when one of three inspected medication carts (Subacute Medication Cart 2) had an unlabeled, unpackaged tablet in the bottom of a cart drawer. This deficient practice placed residents at risk of receiving an incorrect or expired medication. Findings: During a concurrent observation and interview on [DATE] at 2:11 p.m. with Licensed Vocational Nurse 3 (LVN 3) at Subacute Medication Cart 2, one white, round unlabeled and unpackaged tablet was observed on the bottom of a cart drawer. LVN 3 stated the medication should be packaged and labeled when stored in the cart so they can verify the correct medication is being given by comparing it to the resident's orders in the resident's electronic health record (EHR-an electronic version of a resident's medical record, including physician orders). LVN 3 further stated the tablet should have been kept in its original packaging so the expiration date can be verified. During an interview on [DATE] at 2:30 p.m. with the Director of Nursing (DON), the DON stated all medications should be packaged and labeled so medications are not accidentally given to the wrong residents and to reduce the risk of a medication error. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, last reviewed [DATE], the P&P indicated the provider pharmacy dispenses medications in containers that meet legal requirements, and medications should be kept in these containers. The P&P further indicated contaminated medications are immediately removed from stock and disposed of.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 34659 Based on observation, interview and record review, the facility failed to prepare foods in a form designed to meet individual needs when seven of eight residents on puree diet (food that is prepared in a way that is smooth with no lumps and has a texture like pudding) were served puree lemon crisp that was too thick. This deficient practice had the potential to result in a resident having difficulty swallowing and choking. Findings: During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 5/21/2025 at 1:58 p.m. with the Dietary Supervisor (DS) and the Regional Dietary Supervisor (RDS), observed the puree dessert lemon crisp. The DS stated the lemon crisp was too thick to serve to residents. The DS stated it had the potential for someone to have difficulty to swallow the food. The DS stated the dessert should be similar to mashed potatoes, smooth, and should drop off the spoon when conducting the spoon tilt test (a method used to assess the cohesiveness and stickiness of foods, particularly in the context of the International Dysphagia Diet Standardization Initiative (IDDSI, is a globally recognized framework for standardizing the terminology and definitions for texture-modified foods and thickened liquids used by individuals with dysphagia) framework. It involves scooping a food sample onto a spoon and tilting it to observe how the food falls off the spoon). The survey team conducted the spoon tilt test in the presence of the DS and RDS. The DS confirmed that the dessert did not pass the test. The DS stated the goal is to determine if the food hold slides off easily. The DS stated the dessert lemon crisp was too thick. The DS stated it has the potential for someone having difficulty to swallow the food. During a review of the facility's diet manual titled Dysphagia Diet, Puree IDDSI Level 4 dated 2/2025, the diet manual indicated, A diet used in the dietary management of dysphagia with the food texture prepared lump-free, not firm or sticky and holds it shape on a plate. The diet requires no biting or chewing. Any liquids must not separate from the food and the food can fall off a spoon intact. The food is more easily swallowed and prevent aspiration. All prepared recipes should be tested prior to service to ensure the texture meets the IDDSI guidelines. They should pass the fork drip test and spoon tilt test. We recommend using water in the preparation of puree recipes as utilizing water will not alter the nutritional composition. However, broth, milk, or juice may also be used. Refer to your facility registered dietitian for appropriate substitution.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34659 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by failing to: 1. Ensure peppers stored in refrigerator were labeled with a date when placed in the refrigerator. 2. Ensure the temperature of food items on the tray line (a system of food serving in which a tray is moved along an assembly line to ensure a resident gets their prescribed diet) were taken. 3. Ensure Dietary Aide1 (DA 1) did not touch his glasses with a gloved hand multiple times and did not wash hands or change gloves until asked by the Dietary Supervisor to do so. These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in 57 medically compromised residents who received food from the kitchen. Findings: 1. During an initial observation of the kitchen with the Dietary Supervisor (DS) and the Regional Dietary Supervisor (RDS) on 5/19/2025 at 9 a.m., observed bell peppers in the walk-in refrigerator that were not labeled with a date when placed in the refrigerator. The DS stated all foods in the refrigerator should be dated with the date they were placed. During a review of the policy and procedure (P&P) titled, Food Storage: Cold Foods, last reviewed 7/18/2024, the P&P indicated all foods will be stored or wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. 2. During a kitchen tray line (area in the kitchen where foods are assembled from the steamtable to resident's plate) observation on 5/22/2025 at 11:40 a.m., observed tray line. Observed [NAME] 1 checking the temperatures of the food on the tray line. The ADS did not check the temperatures of the following foods: 1. Mashed potatoes 2. Gravy 3. Minced and moist(foods that are prepared soft, moist, and minced or ground) potatoes 4. Soft and bite-sized (a modified diet where foods are soft, tender, and moist) potatoes 5. Soft and bite-sized chicken (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Minced and moist chicken 7. Soft and bite-sized pasta 8. Minced and moist carrots When asked why these food temperatures were not taken, [NAME] 1 and the RDS took the temperatures. During an interview with the DS on 5/22/2025 at 1:36 p.m., the DS stated [NAME] 1 should have taken all the food temperatures on the trayline. The DS stated this is important to prevent bacterial growth. During an interview with [NAME] 1 on 5/22/2025 at 2:10 p.m., [NAME] 1 stated they should have taken all the food temperatures for all items on the trayline. [NAME] 1 stated this was missed because of human error. During a review of the facility's policy and procedure titled, Food Preparation, last reviewed 7/18/2024, the P&P indicated all foods will be held at appropriate temperatures, greater than 135 degrees Fahrenheit (? F, a unit of temperature for food) for hot holding, and less than 41? F for cold food holding. 3. During a kitchen tray line observation on 5/22/2025 at 12:51 a.m., with the DS, observed Dietary Aide 1 (DA 1) touch his face and eyeglasses with his gloved hand. The DS notified the DA 1 to wash their hands and apply new gloves. DA 1 washed their hands and applied new gloves. During an interview with the DS on 5/22/2025 at 1:36 p.m., the DS stated the practice is to wash hands and apply new gloves if a kitchen staff touches their face. The DS stated this is important for infection control. During an interview with DA 1 on 5/22/2025 at 2:05 p.m., DA 1 stated they should have washed their hands and apply new gloves after touching their face. During a review of the facility's policy and procedure titled, Food Preparation, last reviewed 7/18/2024, indicated all staff will practice proper hand washing techniques and glove use. During a review of the facility's policy and procedure titled, Gloves, Requirement to Wear, last reviewed 7/18/2024, indicated whenever gloves are worn, they shall be changed, or replaced as often as hand washing is required.

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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. 50033 Based on interview and record review, the facility failed to ensure the accuracy of a medical record when one of twelve residents investigated under the Advance Directive care area (Resident 34) had an Advance Directive Acknowledgement form that indicated the resident had an Advance Directive when he did not. This deficient practice resulted in inaccurate documentation of the existence of an Advance Directive in Resident 34's medical record. Findings: During a review of Resident 34's Admission Record, the Admission Record indicated the facility admitted the resident on 12/13/2024 with diagnoses including pneumonia (an infection/inflammation in the lungs), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), and schizophrenia (a mental illness that is characterized by disturbances in thought). The Admission Record further indicated Resident 34 is deaf and non-speaking. During a review of Resident 34's Minimum Data Set (MDS - a resident assessment tool), dated 9/17/2025, the MDS indicated Resident 34 required moderate assistance with most activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated an Advance Directive was not completed. During a review of a letter from a regional center (a non-profit agency that oversees the coordination of services for people with developmental disabilities), dated 12/16/2024, the letter indicated Resident 34 is a consumer of the Regional Center due to developmental disabilities. The letter indicated Resident 34 is not capable of providing informed consent and does not have a court appointed conservator or guardian, and a designee from the Regional Center will act on his behalf to provide consent for medically necessary treatments. During an interview on 5/21/2025 at 11:12 a.m. with Resident Representative 1 (RR 1), RR 1 stated he is Resident 34's responsible party from the Regional Center. RR 1 stated Resident 34 has an intellectual disability and is deaf. RR 1 stated he was not aware of any Advance Directive for Resident 34. RR 1 stated Resident 34's family is not involved, and that staff from the Regional Center signs consents (a person must give permission before they receive any type of medical treatment, test, or examination) on the resident's behalf. During a concurrent interview and record review on 5/22/2025 at 2:39 p.m. with the Social Services Director (SSD), Resident 34's Advance Directive Acknowledgement form indicated Resident 34 had executed an Advance Directive. The SSD stated Resident 34 did not have an Advance Directive and the Advance Directive Acknowledgment form was incorrect. The SSD stated the purpose of the Advance Directive Acknowledgment form is to document the presence of an Advance Directive, inform residents that they do not need an Advance Directive to receive care, and give residents the opportunity to create an Advance Directive if they do not have one. (continued on next page)

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F 0842 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, Advance Directive, last reviewed 7/18/2024, the P&P indicated staff will inquire about the existence of an Advance Directive on admission. The P&P indicated if the resident does have an Advance Directive, it will be placed in the resident's medical record. The P&P further indicated if no Advance Directive exists, the facility provides the resident the opportunity to create one.