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	06/04/2026

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the physician when a resident's blood sugar (BS) was elevated, in accordance with facility policy and the physician's order for one of five residents (Resident 48) reviewed under unnecessary medications. This failure placed Resident 48 at risk for delayed assessment and treatment of hyperglycemia (an abnormally high level of sugar [glucose] in the blood, which occurs when the body does not produce enough insulin [medication to manage blood sugar levels in individuals with diabetes, helping convert glucose into energy] or cannot use insulin effectively), which increases the likelihood of serious health complications such as confusion, dehydration, blurry vision, diabetic ketoacidosis (DKA- a life threatening condition caused by insufficient insulin leading to acidic blood), loss of consciousness, and potentially death due to delayed medical intervention. Findings:^^ Duringˆaˆreview of Residentˆ48'sˆadmission Record, the admission Recordˆindicated the facility originally admitted Resident 48ˆon 4/29/2025ˆand re-admitted ˆtheˆresident on 5/16/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and sepsis (a life-threatening blood infection). ˆ During a review of Residentˆ48's Minimum Data Set (MDS-a resident assessment tool), datedˆ2/27/2026,ˆthe MDS indicated Residentˆ48's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated that Resident 48 was receiving medications classified as high risk for hypoglycemia (low blood sugar), including insulin. During a review of Resident 48's Order Summary Report dated 6/1/2026, the Order Summary report indicated an order, dated 5/16/2026, for Insulin Lispro (a fast acting insulin used to help people with diabetes control their blood sugar) 100 units/milliliter (u/ml-units of measurement), inject as per sliding scale and notify physician if less than (<) 70^^milligrams per deciliters (mg/dL-unit used to measure the concentration of a substance in a specific volume of liquid) or greater thanˆ(>) 400ˆmg/dL. During a concurrent interview and record review on 6/2/2026 at 11:50 a.m. with the Director of Nursing (DON), Resident 48's physician orders 5/16/2026ˆwere reviewed. DON statedˆthe physician order indicated to callˆthe physicianˆif Resident 48's blood sugar (BS) was greater than 400ˆmg/dL. During a concurrent interview and record review on 6/2/2026 at 11:55 a.m. with the DON, Resident 48's MAR for 5/2026ˆwas reviewed. The DON statedˆthe MAR indicated the following BS values on the corresponding dates and times: 5/17/2026ˆ450ˆmg/dLˆ12p.m. 5/17/2026ˆ444 mg/dLˆ6 p.m. 5/20/2026ˆ319ˆmg/dLˆ12 a.m. 5/20/2026ˆ326 mg/dLˆ6 a.m. 5/21/2026ˆ316ˆmg/dLˆ12 a.m. 5/21/2026ˆ355 mg/dLˆ6 a.m. 5/22/2026ˆ397ˆmg/dLˆ12 a.m. 5/22/2026ˆ379 mg/dLˆ6 a.m. 5/23/2026ˆ442 mg/dLˆ12 a.m. 5/23/2026ˆ444 mg/dL^^ 6 a.m. 5/24/2026ˆ340ˆmg/dLˆ12 a.m. 5/24/2026ˆ324 mg/dLˆ6 a.m. During a concurrent interview and record review on 6/2/2026 at 12:02 p.m. with the DON, Resident 48's medical record including progress note and change of condition (COC) form for the month of 5/2026 were reviewed. The DONˆstatedˆthere were no documentation in the progress notes or COC thatˆindicated the physician was notified for the following dates and times when Resident 48's BS was high: (continued on next page)

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

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/17/2026ˆ450ˆmg/dLˆ12p.m. 5/17/2026ˆ444 mg/dLˆ6 p.m. 5/20/2026ˆ319ˆmg/dLˆ12 a.m. 5/20/2026ˆ326 mg/dLˆ6 a.m. 5/21/2026ˆ316ˆmg/dLˆ12 a.m. 5/21/2026ˆ355 mg/dLˆ6 a.m. 5/22/2026ˆ397ˆmg/dLˆ12 a.m. 5/22/2026ˆ379 mg/dLˆ6 a.m. 5/23/2026ˆ442 mg/dLˆ12 a.m. 5/23/2026ˆ444 mg/dLˆˆ 6 a.m. 5/24/2026ˆ340ˆmg/dLˆ12 a.m. 5/24/2026ˆ324 mg/dLˆ6 a.m. The DON stated that when the physician is notified, the licensed staff should document the notification in the nurse's progress notes or on the Change of Condition (COC) form. The DON stated the physician should have been notified when Resident 48's BS levels were greater than 400 mg/dL and also when a resident has a blood sugar reading is higher than 300 mg/dL during all or part of two consecutive days physician, as indicated in the facility policy. The DON stated that the failure to report the high blood sugar levels to the physician placed Resident 48 at increased risk for serious health complications such as confusion, blurry vision, coma, and potentially death. During a concurrent interview and record review on 6/3/2026 at 3:31 p.m. with the Minimum Data Set (MDS) nurse, Resident 48's medical record including progress notes and COC form for the month of 5/2026 were reviewed. The MDS nurse stated there was no COC or progress note that indicated the physician was notified when Resident 48's BS was higher than 400 mg/dL on 5/17/2026ˆatˆ12p.m, 5/17/2026ˆatˆ6 p.m., 5/23/2026ˆatˆ12 a.m., and 5/23/2026ˆatˆ6 a.m. The MDS nurse stated that physicians should be notified because they may need to adjust the resident's insulin dose and explained that high blood sugar can lead to complications such as sweating, blurry vision, weakness, and DKA. During a review of the facility's policy and procedure (P&P) titled Diabetes - Clinical Protocol, reviewed 4/23/ 2026, the P&Pˆindicatedˆunderˆtheˆsectionˆhyperglycemia that staff will notify the practitioner as soon as possible when the resident has blood glucose readings higher than 300 mg/dl during all or part of 2 consecutive days. The provider will order desired glucose targets and monitoring regimens, as well as parameters for reporting information related to blood sugar management. The staff will incorporate orders and reporting parameters into the Medication Administration Record and care plan. The provider will adjust treatments based on these results and other factors such as glycosuria, weight gain or loss, hypoglycemic episodes, etc. During a review of the facility's (P&P) titled Nursing Care of the Older Adult with Diabetes Mellitus, reviewed 4/23/ 2026, the P&Pˆindicatedˆfollowˆtheˆprovider orders for glucose monitoring. Complications associated with diabetes can be attributed to: (1) uncontrolled hyperglycemia and subsequent damage to the vasculature; can lead to a. cardiovascular and cerebrovascular disease, including heart disease and stroke; b. cognitive impairment; c. kidney disease; d. glaucoma, cataracts, retinopathy, blindness; e. nerve damage (diabetic neuropathy); f. foot complications - neuropathy, dry skin, calluses, poor circulation, ulcers; g. skin problems - fungal/bacterial infections, itching, diabetic dermopathy; and/or h. gastroparesis (delayed stomach emptying). Diabetic ketoacidosis (DKA) (diabetic coma). Ketoacidosis occurs when hyperglycemia is untreated and the cells begin to metabolize fat for energy. The byproduct of fat metabolism is ketones, which. build up quickly in the blood. Diabetic ketoacidosis is a life-threatening emergency that needs immediate medical attention. Symptoms include: a. High blood sugar; b. Ketones in the urine; c. Nausea and/or vomiting; d. Weakness and fatigue; e. Shortness of breath; f. Sweet or fruity odor or breath; g. Confusion; and/or h. Coma.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on interview and observations, the facility failed to maintain resident protected health information ([PHI] - any health information that can be used to identify a specific individual which must remain confidential to prevent harmful consequences) by not shredding or covering pharmacy medication labels (a label that includes the residents name, date of birth , name of pharmacy, name of medication, dose, its indication and instructions of use) containing resident medical information on medication bubble packs (medication packaging system that contains individual doses of medication per bubble) and medication manufacturer packages, prior to disposing in the waste container, affecting Resident 6, 48 and 73 in one (1) of two (2) inspected Medication Rooms (Medication Room Subacute.) As a result, the privacy and confidentiality of Resident 6, 48 and 73's medical records were jeopardized and not securely maintained. Findings: During a concurrent observation and interview on 6/2/2026 at 2 p.m., with Registered Nurse 2 (RN 2) in Medication Room Subacute, there was a red plastic waste container containing disposed medication packages and bubble packs with the pharmacy labels intact and attached to them. One (1) manufacturer medication package for Resident 48 and two (2) medication bubble packs for Resident 6 and 73 with the pharmacy label intact were visible in the waste container. RN 2 stated a third-party (an outside contracted entity not part of the facility) vendor (an individual or company that sells goods or services to someone else) routinely picks up the waste containers to dispose (discard) of the wasted medications. RN 2 stated that medications in the waste container should not contain resident health information and labels with PHI should be removed from packages and packs prior to placing them in the waste container to maintain resident confidentiality. RN 2 stated this failure was considered a Health Insurance Portability and Accountability Act ([HIPPA] - a federal law to protect and secure medical records and other PHI from being disclosed without consent or knowledge) violation as resident health information was visibly exposed to third-party vendors, who are not authorized to obtain resident PHI. During an interview on 6/4/2026 at 10:56 a.m., with the Director of Nursing (DON), the DON stated that no medication should be disposed of in waste containers with pharmacy labels and resident PHI affixed to medication manufacturer packages and bubble packs to prevent HIPPA violation. The DON stated that pharmacy labels should be removed from them prior to disposing of in the waste containers to maintain confidentiality, and those labels should be disposed of in the shredder. The DON stated that the facility failed to protect Resident 6, 48 and 73's privacy and confidentiality by failing to remove pharmacy labels from medication packages and bubble packs prior to disposing them in the waste container in Medication Room subacute visibly exposing resident PHI. During a review of the facility's policy and procedures (P&P), titled Confidentiality of Information and Personal Privacy, last reviewed 4/3/2026, the P&P indicated: Our facility will protect and safeguard resident confidentiality and personal privacy. 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her: Medical treatment 4. Access to resident personal and medical records will be limited to authorized staff and business associates. During a review of the P&P titled Protected Health Information [PHI], Management and Protection of, last reviewed 4/3/2026, the P&P indicated: PHI shall not be used or disclosed except as permitted by current federal and state laws. 10. Health information may be considered not to be individually identifiable in the following circumstances: b. the following identifiers of the resident . are removed: 1. Names 7. Medical record numbers 9. Account numbers.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 75) was free from unnecessary (any medication in excessive dose, excessive duration, without adequate indication for its use and monitoring) use of psychotherapeutic drug (any medication capable of affecting the mind, emotions, and behavior) in accordance with facility policy and procedures by failing to monitor^episodes of anxiety manifested by repetitive worrying about her health condition for buspirone (a psychotropic medication used for anxiety) every shift between 5/1/2026 and 6/3/2026. This deficient practice had the potential to place Resident 75 at risk for significant adverse consequence (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic drug, which could result to impairment or decline in the residents' mental, physical condition, functional, and psychosocial status. Findings: During a review of Resident 75's admission Record (a document containing demographic and diagnostic information,) dated 6/4/2026, the admission Record indicated Resident 75 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including anxiety. During a review of Resident 75's Order Summary Report, dated 6/4/2026, the report indicated Resident 75 was prescribed buspirone 10 milligram ([mg] - a unit of measure of mass) to give one (1) tablet by mouth two (2) times a day for anxiety manifested by repetitive worrying about her health condition, starting 4/1/2026. During a review of Resident 75's Care Plan, revised 9/18/2024, the Care Plan indicated for use of buspirone to monitor episodes of anxiety manifested by repetitive worrying about her health condition every shift. During a review of Resident 75's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for May 2026 and June 2026, the MAR indicated Resident 75 was prescribed and administered buspirone 10 mg tablet by mouth two (2) times a day for anxiety manifested by repetitive worrying about her health condition, at 9 a.m. and 5 p.m. The MARs did not contain documentation for monitoring episodes of anxiety manifested by repetitive worrying about her health condition every shift. During a concurrent record review and interview on 6/3/2026 at 3:09 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 75's admission record, Order Summary, MARs, Care plan revised 9/18/2024 and acknowledged the Care Plan indicated to monitor episodes of anxiety manifested by repetitive worrying about her health condition every shift for use of buspirone. The DON also acknowledged the May and June 2026 MARs did not contain documentation that episodes of anxiety manifested by repetitive worrying about her health condition every shift for use of buspirone were monitored. The DON stated that without monitoring episodes of anxiety it was unknown if buspirone was effective treating the anxiety potentially resulting in the physician making inaccurate assessments of the medication's effectiveness, preventing dose reductions, discontinuation or even making unnecessary dose increases. The DON stated that the facility failed to monitor episodes of anxiety for the use of buspirone placing Resident 75 at risk of continuing unnecessary psychotropic medication potentially resulting in adverse consequences and negatively impacting Resident 75's well-being. The DON stated the monitoring will be immediately initiated in Resident 75's MAR. During a review of review facility's Policy and Procedures (P&P) titled Behavioral Management, last reviewed 4/3/2026, the P&P indicated: The facility will monitor identified residents who exhibit behavioral symptoms. During a review of review facility's P&P titled Psychotropic Medication Use, last reviewed 4/3/2026, the P&P indicated: A psychotropic drug is any medication that affects brains activities associated with mental processes and behavior, which includes but is not limited to.anxiolytics. 10. Facility staff should monitor resident's behavior.Facility staff should monitor behavioral triggers, episodes and symptoms. Facility staff should document the number and/or intensity of symptoms.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for three (Resident 32, Resident 48, and Resident 75) of 19 sampled residents by failing to: 1.Ensure that Resident 32's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) included measurable goals and outcomes for cerebrovascular accidents ([CVA] - an interruption in the flow of blood to cells in the brain] caused by heart failure,) prophylaxis ([PPX] - action taken to prevent disease,) and use of enoxaparin (medication used to prevent CVA and Deep Vein thrombosis [DVT] - a condition when a blood clot forms in one or more of the deep veins in the body). As a result, Residents 32 did not have an identified goal to monitor the effectiveness of Resident 32's enoxaparin use related to CVA PPX. 2. Implement a care plan intervention to monitor episodes of anxiety manifested by repetitive worrying about her health condition every shift. As a result, Resident 75 did not have monitoring for episodes of anxiety with the use of buspirone (a psychotropic medication used for anxiety,) between 5/1/2026 and 6/3/2026. 3. Implement a care plan intervention to monitor signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) as indicated in Resident 48's care plan. These deficient practices had the potential to cause Resident 32, 48 and 75 to receive suboptimal (less than the highest standard or quality) care, for Resident 32, to not know how to manage and care for CVA PPX, or how effective the prescribed enoxaparin therapy was for CVA PPX, for delaying assessment and treatment of hypoglycemia or hyperglycemia to Resident 48 , and for Resident 75, unable to assess the effectiveness of buspirone for anxiety, leading to the use of unnecessary medications causing serious health complications such as bleeding, recurrent CVA, medication overdose (giving doses beyond the necessary amount), ultimately negatively impacting their physical, mental, and psychosocial well-being potentially resulting in hospitalization and/or death. Findings: 1. During a review of Resident 32's admission Record (a document containing demographic and diagnostic information,) dated 6/4/2026, the admission Record indicated Resident 32 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnosis including heart failure, morbid obesity, and difficulty walking. During a review of Resident 32's hospital discharge records dated 5/18/2026, the record indicated for Resident 32 to continue taking enoxaparin 0.4 ml once a day SQ, next dose to be given on 5/19/2026 at 9 a.m. During a review of Resident 32's Order Summary (a document containing orders prescribed by the doctor), dated 6/3/2026, the report indicated Resident 32 was prescribed enoxaparin 40 milligram ([mg]- a unit of measure of mass) per 0.4 milliliter ([ml] – a unit of measure of volume) subcutaneously ([sq] – under the skin) in the evening for CVA, starting 5/19/2026. During a review of Resident 32's Care Plan, initiated 5/4/2026, the Care Plan was not revised and did not include goals, duration and outcome for enoxaparin use for CVA PPX. During a concurrent record review and interview on 6/3/2026 at 3:09 p.m., with the Director of Nursing (DON,) the DON reviewed Resident 32's admission record, Order Summary, Care plan dated 5/4/2026 and acknowledged the Care Plan does not have goals, duration and outcomes for enoxaparin use for CVA PPX. The DON stated that the Care Plan should include goals, duration and outcomes for (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' areas of concern. The DON stated there should be a Care Plan for enoxaparin for CVA PPX to provide individualized care and not having that care plan does not provide patient centered care for Resident 32. The DON stated that without a Care Plan for enoxaparin, the facility will not be able to identify improvements or concerns, and whether goals were met with the current treatment for CVA PPX for Resident 32. The DON stated the facility failed to initiate a comprehensive Care Plan for enoxaparin use for CVA PPX to accurately reflect the needs of Resident 32 and to maintain the highest level of functionality and quality of life with measurable goals and outcomes. The DON stated that the Care Plan for CVA PPX for Resident 32 will be immediately revised. During a review of review facility's Policy and Procedures (P&P,) titled Care Plan Comprehensive, last reviewed 4/3/2026, the P&P indicated: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs hall be developed for each resident. The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs that are identified in the comprehensive assessment. 1.Each resident's comprehensive care plan is designed to: f. reflect treatment goals, timetables, and objectives in measurable outcomes. 2. The comprehensive care plan includes the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being c. The resident's goals for admission and desired outcomes. 6. The resident's comprehensive care plan is developed within seven (7) days of completion of the resident's comprehensive assessment (MDS.) 7. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident's condition change. 8. The Interdisciplinary Team is responsible for evaluation and updating of care plans: a. when there has been a significant change in resident's condition c. when the resident has been readmitted to the facility from a hospital stay and d. at least quarterly. 2. During a review of Resident 75's admission Record dated 6/4/2026, the admission Record indicated Resident 75 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including anxiety. During a review of Resident 75's Order Summary Report, dated 6/4/2026, the report indicated Resident 75 was prescribed buspirone 10 milligram ([mg] – a unit of measure of mass) to give (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	one (1) tablet by mouth two (2) times a day for anxiety manifested by repetitive worrying about her health condition, starting 4/1/2026. During a review of Resident 75's Care Plan, revised 9/18/2024, the Care Plan indicated for use of buspirone to monitor episodes of anxiety manifested by repetitive worrying about her health condition every shift. During a review of Resident 75's Medication Administration Record ([MAR] - a record of mediations administered to residents,) for May 2026 and June 2026, the MAR indicated Resident 75 was prescribed and administered buspirone 10 mg tablet by mouth two (2) times a day for anxiety manifested by repetitive worrying about her health condition, at 9 a.m. and 5 p.m. The MARs did not contain documentation for monitoring episodes of anxiety manifested by repetitive worrying about her health condition every shift. During a concurrent interview and record review on 6/3/2026 at 3:09 p.m., with the DON, the DON reviewed Resident 75's admission record, Order Summary, MARs, Care plan revised 9/18/2024 and acknowledged the Care Plan indicated to monitor episodes of anxiety manifested by repetitive worrying about her health condition every shift for use of buspirone. The DON also acknowledged the May and June 2026 MARs did not contain documentation that episodes of anxiety manifested by repetitive worrying about her health condition every shift for use of buspirone were monitored. The DON stated that without monitoring episodes of anxiety it was unknown if buspirone was effective treating the anxiety potentially resulting in the physician making inaccurate assessments of the medication's effectiveness, preventing dose reductions, discontinuation or even making unnecessary dose increases. The DON stated that the facility failed to implement the care plan for monitoring episodes of anxiety for the use of buspirone placing Resident 75 at risk of continuing unnecessary psychotropic medication potentially resulting in adverse consequences and negatively impacting Resident 75's well-being. The DON stated the monitoring will be immediately initiated in Resident 75's MAR. During a review of review facility's P&P titled Behavioral Management, last reviewed 4/3/2026, the P&P indicated: Behaviors and interventions will be addressed in the care plan. The facility will monitor identified residents who exhibit behavioral symptoms. During a review of review facility's P&P titled Psychotropic Medication Use, last reviewed 4/3/2026, the P&P indicated: A psychotropic drug is any medication that affects brains activities associated with mental processes and behavior, which includes but is not limited to.anxiolytics. 10. Facility staff should monitor resident's behavior.Facility staff should monitor behavioral triggers, episodes and symptoms. Facility staff should document the number and/or intensity of symptoms. During a review of review facility's Policy and Procedures (P&P,) titled Care Plan Comprehensive, last reviewed 4/3/2026, the P&P indicated: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs hall be developed for each resident. The facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs that are identified in the comprehensive assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1.Each resident's comprehensive care plan is designed to: f. reflect treatment goals, timetables, and objectives in measurable outcomes. 2. The comprehensive care plan includes the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being c. The resident's goals for admission and desired outcomes. 6. The resident's comprehensive care plan is developed within seven (7) days of completion of the resident's comprehensive assessment (MDS.) 7. Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident's condition change. 8. The Interdisciplinary Team is responsible for evaluation and updating of care plans: a. when there has been a significant change in resident's condition c. when the resident has been readmitted to the facility from a hospital stay and d. at least quarterly. 3. Duringˆaˆreview of Residentˆ48'sˆadmission Record, the admission Recordˆindicated the facility originally admitted Resident 48ˆon 4/29/2025ˆand re-admitted ˆtheˆresident on 5/16/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), type II diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), andˆsepsis (a life-threatening blood infection).ˆ ˆˆ During a review of Residentˆ48's MDS, dated [DATE],ˆthe MDS indicated Residentˆ48's cognition (the mental action or process ofˆacquiringˆknowledge and understanding through thought, experience, andˆthe senses) was severely impaired. The MDS indicated that Resident 48 was receiving medications classified asˆhigh riskˆfor hypoglycemia (low blood sugar), including insulinˆ(a medication that regulates sugar in the blood)ˆand anticoagulant (such as warfarin, heparin, or low-molecular weight heparin).ˆ During a review of Residentˆ48's Physician Order Summary Report, active orders as ofˆ5/16/2026, the Physician Order Summary Reportˆindicatedˆthe following orders:ˆˆ 1.Heparin Sodium Injection Solution 5000 UNIT/MLˆ(units (measurement of how active a medication isˆper milliliter),ˆInject 5000 unit subcutaneouslyˆ(under the skin)ˆone time a dayˆfor deep vein thrombosis (DVT) a serious condition where a blood clot forms in a deep vein, prophylaxis(prevention)ˆˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Anticoagulant Heparin Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds.ˆ 3. Insulin Lispro (aˆfast-actingˆinsulin used to help people with diabetes control their blood sugar after meals) 100 u/ml (units/milliliter - units of measurement), inject as per sliding scale, notify physician if less than (<) 70ˆmg/dL or greater thanˆ(>) 400ˆmg/dL.ˆˆˆˆ During a review of Resident 48's Care Plan Report, with an initiated date ofˆ4/30/2026, last revised onˆ6/1/2026, the Care Plan ReportˆindicatedˆResident 48 is at risk forˆhypoglycemia and hyperglycemia.ˆTheˆinterventions, with initiatedˆdate of 4/30/2026ˆincludedˆto monitor for signs and symptoms of hyper/hypoglycemia and report abnormal findings toˆphysicians.ˆˆThe goalˆindicatedˆthat Residentˆ48ˆwill be free of all signs and symptoms ofˆhypoglycemia andˆhyperglycemia such as:ˆsweating, trembling, thirst, fatigue, weakness, blurred visionˆthrough next review date.ˆ During a concurrent interview and record review on 6/2/2026 at 12:10ˆp.m. with the DON, Resident 48's MAR dated 5/17/2026 to 5/31/2026 was reviewed. ˆThe DONˆstatedˆResident 48's MARˆindicatedˆResident 48 received Insulin injection from 5/17/2026 to 5/31/2026. The DONˆstatedˆlicensed nurses shouldˆmonitorˆand document the side effects of Insulin administration inˆtheˆEMARˆincluding signs and symptoms of hypoglycemia and hyperglycemia. ˆˆThe DON reviewed Resident 48's EMAR dated 5/17/2026 to 5/31/2026. ˆThe DONˆstatedˆthere was no record toˆindicateˆthat Resident 48's wasˆmonitoredˆforˆhypoglycemia and hyperglycemia.ˆTheˆDONˆstatedˆregular monitoring of the residents allows staff toˆidentifyˆearly signs and symptoms ofˆhypoglycemia and hyperglycemiaˆand promptly report to the physiciansˆto help prevent harm to residents.ˆˆ During a review of the facility's P&P titled Care Plan Comprehensive, reviewed 4/23/ 2026, the P&PˆindicatedˆthePlan facility's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectivates and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment.ˆ ˆ During a review of the facility's P&P titled Diabetes - Clinical Protocol, reviewed 4/23/ 2026, the P&PˆindicatedˆthePurpose of policy is to provide an overview of diabetes in the older adult, its symptoms and complications, and the principles of glucose monitoring.ˆSigns and symptoms of hyperglycemia may include the following:ˆ a.ˆIncreasedˆthirst;ˆˆ b.ˆFrequentˆurination;ˆ c.ˆˆSugar in theˆurine;ˆ d.ˆFatigue;ˆ e.ˆHeadacheˆ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	f.ˆBlurred visionˆ Diabetic ketoacidosis (DKA) (diabetic coma). Ketoacidosis occurs when hyperglycemia is untreated and the cells begin to metabolize fat for energy. The byproduct of fat metabolism is ketones, which. build up quickly in the blood. Diabetic ketoacidosis is a life-threatening emergency that needs immediate medical attention. Symptoms include:ˆ a.ˆHigh bloodˆsugar;ˆ b.ˆKetones in theˆurine;ˆ c.ˆNausea and/orˆvomiting;ˆ d.ˆWeakness andˆfatigue;ˆ e.ˆShortness ofˆbreath;ˆ f.ˆSweet or fruity odor orˆbreath;ˆ g.ˆConfusion; and/orˆ h.ˆComa.ˆ Monitoringˆfor andˆmanaging Treatment-Related Hypoglycemiaˆthe staff and provider willˆmonitorˆfor and manage hypoglycemiaˆappropriately. ˆ

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to ensure residents who were 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 (UTI, common infections that happen when bacteria infect the urinary tract) for three of three sampled residents (Resident 25, Resident 10, and Resident 99) reviewed under urinary catheter care area by failing to: a. Ensure Resident 25's urinary catheter tubing (a tube that is inserted into the bladder, allowing urine to drain) was positioned without coils or loops to allow urine to flow freely into the urinary catheter bag (container that connects to a urinary catheter and collects urine). b. Ensure Resident 10's urinary catheterˆ(a tube that is inserted into the bladder, allowing urine to drain)ˆtubing was positioned to prevent the formation of a dependent loop (a urinary catheter dependent loop isˆa U-shaped sag in the drainage tubing that falls below the collection bag, creating a low point that disrupts gravity drainage causing urine to pool, leading to bacteria growth, reduced bladder drainage, and a high risk of catheter-associated urinary tract infections) and to allow the urine to flow freely into the collection bag. These failures placed Resident 25 and Residentˆ10 at risk for urinary retention, backflow of urine, and UTI. c. Ensure licensed nurses implement the physician's orderˆtoˆmonitorˆurine output, andˆmonitorˆsigns and symptoms of UTI for Resident 99.This failure placed the resident at risk for delayed identification and assessment of a UTI, which could result in delayed treatment and adverse health outcomes. Findings: a. During a review of Resident 25's admission Record, the admission Record indicated the facility admitted Resident 25 on [DATE] with diagnoses including neuromuscular dysfunction of bladder (when nerve damage interrupts the communication between the brain, spinal cord, and bladder muscles), dysphagia (a disorder that makes it difficult to speak) and muscle weakness. During a review of Resident 25's Minimum Data Set (MDS – a resident assessment tool), dated [DATE], the MDS indicated Resident 25 was usually understood (difficulty finishing some words or finishing thoughts, but is able if prompted or given time to answer) and usually understands others. The MDS indicated Resident 25 required substantial (helper does more than half the effort) assistance from facility staff for toileting and bathing. During a review of Resident 25's Order Summary Report, active as of [DATE], the Order Summary Report indicated Resident 25 had an order dated [DATE] for: - Urinary Catheter: Foley Catheter (FC - a brand of indwelling catheter) #FR 16(French, 16 is the size of the tubing) x10ml (milliliter – a unit of volume measurement) During an observation, on [DATE], at 9:08 a.m., inside Resident 25's room, Resident 25 was lying down in bed with a urinary catheter bag hanging on the left side of the resident's bed frame. The urinary catheter tubing hung below the middle-left side of the bed and had a coil and a long loop with urine backing up into the resident. The coiled portion of the urinary catheter tubing contained yellow liquid with sediments. During a concurrent observation and interview, on [DATE], at 9:12 a.m., inside Resident 25's room, (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with Registered Nurse (RN 1), RN 1 stated Resident 25's urinary catheter tubing had a coil and loop and contained yellow liquid with white sediments. RN 1 stated the urinary catheter tubing should be straight in order to drain the urine into the urinary catheter bag. RN 1 further stated if the urine is not draining properly, the resident can possibly get an infection because the urine might backflow into his body. RN 1 stated the urinary catheter should be hung towards the end of the bed frame more to prevent the coiling/looping. During an interview with the Director of Nursing (DON), on [DATE], at 1:04 pm, the DON stated the urinary catheter tubing should not be coiled or kinked and below the level of the bladder. The DON stated if the urinary catheter tubing is coiled or looped, urine can back up into the resident. The DON further stated if urinary retention occurs, it could result in bladder distension (when the bladder becomes larger from storing excess urine) and can possibly cause a UTI. During a review of the facility`s providedˆmanufacturer`s instruction/literature (MI/L)ˆtitledˆPre-coveredˆUrinary DrainageˆBag, the MI/LˆindicatedˆthatˆIn any drainage collection system, the tubing should hang straight fromˆbedside to the drainage bag. This helpsˆpermitˆgood flow and helps to minimizeˆmigration of bacteria due to urine pooling.ˆˆˆ b. During a review of Residentˆ10`s admission Record, the admission Record indicated the facility originally admitted the resident onˆ[DATE]ˆand readmitted on [DATE] with diagnosis including,ˆobstructiveˆand refluxˆuropathy (a blockage in the urinary tract that prevents urine from flowing properly, causing it to back up and potentially damage the kidneys)ˆandˆacute kidney failure (a sudden, rapid decline in kidney function occurring within hours or days).ˆ During a review of Residentˆ10's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Residentˆ10ˆrequired partial/moderate assistanceˆ(helper does more than half the effort) from staff forˆtoileting hygiene, lower bodyˆdressing, putting on and taking off footwearˆand supervision or touching assistanceˆ(helper provides verbal cues)ˆwithˆupper body dressing and personal hygiene.ˆ During a review of Residentˆ10`sˆOrder Summary Report, as ofˆ[DATE], the Order Summary Report indicated an order forˆFoleyˆCatheterˆ(a flexible, indwelling tube inserted through the urethra into the bladder to continuously drain urine into a bag)ˆ16ˆFrenchˆx 10ˆccˆ(French;ˆ16ˆinches in length;ˆ5ccˆballon secures catheter in place)ˆattached to urinary drainage bag at bedside every shiftˆfor Foley catheter use related to neuromuscular dysfunction of bladder (a bladder condition in which nerve or muscle problems affect the person's ability to control urination). During a concurrent observation and interview on [DATE] at 11:04 a.m. with Licensed Vocational Nurse 1 (LVN 1) in Resident 10`s room,ˆobservedˆthe resident`s urinary catheter tubing forming a loop filled with stagnant (not flowing to the drainage bag) urine with white sediments. LVN 1ˆstatedˆthat the urine in the catheter tubing should be free flowing and should not form a loop as this will potentially cause the contents of the tubing to back up into the resident`s bladder which can lead to infection. ˆ Duringˆanˆinterviewˆonˆ[DATE] atˆ11:21 a.m. with Registered Nurse 1 (RN 1),ˆRN 1 stated thatˆcaring for a resident with aˆurinaryˆcatheterˆincludes emptying the urinary drainage bag, monitoring for signs and symptoms of UTIˆand ensuring the urine is free following in the tubing by making sureˆthe tubing is not forming a loop. RN 1ˆstatedˆthatˆa coiled or looped tubingˆcan obstruct the flow of urineˆandˆcan potentiallyˆcause UTI.ˆ (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a review of the facility`s providedˆmanufacturer`s instruction/literatureˆ(MI/L)ˆtitledˆPrecoveredˆUrinary DrainageˆBag,ˆthe MI/Lˆindicatedˆthatˆinˆany drainage collection system, the tubing should hang straight fromˆbedside to the drainage bag. This helpsˆpermitˆgood flow and helps to minimizeˆmigration of bacteria due to urine pooling.ˆˆˆ c. During a review of Resident 99's admission Record, the admission Record, indicated the facility admitted the resident on [DATE] with diagnoses including,ˆbenign prostatic hyperplasiaˆ(BPH-ˆa noncancerous enlargement of the prostate gland caused by the excessive growth of prostate cell), sepsisˆ(a serious condition in which the body responds improperly to an infection), and pressure ulcer of sacralˆregion (a localized injury to the skin and underlying tissue over the tailbone).ˆTheˆadmission RecordˆindicatedˆthatˆResident 99ˆexpired on [DATE]ˆatˆthe facility.ˆˆ ˆˆˆ During a review of Residentˆ99's MDS, the MDS indicated the residentˆrarely/neverˆmakesˆself-understoodˆand rarely/never understand others.ˆThe MDS indicated that Residentˆ99ˆisˆtotally dependentˆon staff for activities of daily living (these activities are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting).ˆˆ ˆ During aˆconcurrent interviewˆand record review on [DATE]ˆatˆ9:18 a.m.ˆwith the Director of Nursing (DON), the following were reviewed:ˆˆ ˆ 1. Resident 99`sˆOrder Summary Reportˆas of [DATE], which indicated the following orders including but not limited to: ˆ -Measureˆurine output every shiftˆfor suprapubic catheter useˆ(a flexible tube surgically inserted through your lower abdomen directly into your bladder to drain urine)ˆrelated to BPH dated [DATE].ˆˆ -Monitor for signs and symptomsˆofˆurinary tract infection (UTI-ˆa bacterial infection in the urinary system, including the bladder and kidneys), i.e.ˆchills, fever, altered level of consciousness, unusual color or cloudiness, retention, pervasive foul odor, sediments and bladder retentionˆevery shift for SPC use related to BPH,ˆfor suprapubic catheter use, dated [DATE].ˆ ˆ 2. Resident 99`s Treatment Administration Record (TAR-ˆa foundational healthcare document used to track, schedule, and legally log ongoing treatments, therapies, and medications) forˆthe month of February 2026.ˆ The DON statedˆtheˆTARˆindicatedˆthat onˆ[DATE],ˆ[DATE], [DATE], [DATE], and [DATE] (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during theˆday shift,ˆthere was noˆdocumentation of urine output and monitoring forˆsigns and symptoms of UTI. The DON stated that it is important to monitor Resident 99's urine output and assess for signs and symptoms of UTI to ensure timely intervention and prevent the infection from worsening, which could progress to sepsis if not promptly treated. The DON further stated that physician orders should be carried out to ensure the resident received quality of care and to maintain adherence to professional standards of practice. During a review of the facility`s policy and procedure (PP) titled Physician Orders, last reviewed on [DATE], the PP indicated thatˆthe .licensed nurse receiving the order willˆbe responsible forˆdocumenting and implementing the order. Medication/treatment orders will be transcribed onto theˆappropriate residentˆadministration record.ˆ

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide residents with necessary respiratory care and services that is in accordance with professional standards of practice to three of five sampled residents (Resident 7 Resident 48, and Resident 5) reviewed under the respiratory care area by failing to ensure the residents' oxygen tubing (a flexible, clear hose that delivers oxygen to a patient during oxygen therapy) was changed every seven days.These deficient practices had the potential to negatively affect the provision of care and services related to oxygen therapy and placed the residents at increased risk for respiratory distress and infection. Findings: a. Duringˆaˆreview of Residentˆ7'sˆadmission Record, the admission Recordˆindicated the facility originally admitted Resident 7ˆon 6/16/2022ˆand re-admitted ˆtheˆresident on 1/14/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), and hypertension (high blood pressure).ˆ During a record review of Resident 7's History and Physical (H&P) dated 12/15/2025, the H&PˆindicatedˆResident 7 does not have the capacity to understand and make decisions.ˆˆˆ During a review of Residentˆ7's Minimum Data Set (MDS – a resident assessment tool) MDS, dated [DATE],ˆtheˆMDS indicated Resident 7's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. During a review of Resident 7's Order Summary Report dated 6/1/2026, the Order Summary report indicated an order, dated 1/14/2024, for oxygen at 4 liters per minute (L/min-unit of measurement of volume flow rate) every shift through the ventilator (a medical machine that helps a person breathe or breathe entirely for them). b. Duringˆaˆreview of Residentˆ48'sˆadmission Record, the admission Recordˆindicated the facility originally admitted Resident 48ˆon 4/29/2025ˆand re-admitted ˆtheˆresident on 5/16/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing),and sepsis (a life-threatening blood infection). ˆ During a review of Residentˆ48's MDS, dated [DATE],ˆthe MDS indicated Residentˆ48's cognition was severely impaired. The MDS indicated Resident was 48 receiving oxygen therapy. ˆ During a review of Resident 48's Order Summary Report dated 6/1/2026, the Order Summary report indicated an order, dated 5/15/2026, for oxygen at 4 L/min every shift through the ventilator. ˆ (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/1/2026 at 10:08 a.m., with Respiratory Therapist 2 (RT 2), inside Resident 48's room, Resident 48 was observed in bed receiving oxygen through the ventilator at 4 L/min. Observed Resident 48's oxygen tubing dated 5/18/2026. RT 2 stated the oxygen tubing should be changed every seven (7) days to help prevent infection. RT 2 stated the oxygen tubing should have been changed on 5/25/2026. During a concurrent observation and interview on 6/1/2026 at 10:12 a.m., with RT 2 , inside Resident 7's room, Resident 7 was observed in bed receiving oxygen through the ventilator at 4 L/min. Observed Resident 7's oxygen tubing and oxygen humidifier (a device thatˆadds moisture to supplemental oxygen before it is delivered to your airway) dated 5/18/2026. RT 2 stated it is the policy of the facility to change oxygen tubing every seven (7) days and as needed. RT 2 stated Resident 7's oxygen tubing should have been changed on 5/25/2026. During a concurrent interview and record review on 6/02/2026 at 11:05 a.m. with the Director of Nursing (DON), the facility policy titled SNF Clinic Oxygen Administration reviewed on 4/23/2026, was reviewed. The DON stated facility follows the policy titled SNF Clinic Oxygen Administration on replacement of oxygen therapy equipment. The DON stated that, according to the policy and facility practice, oxygen tubing should be dated and replaced every seven days and as needed to prevent infection. During an interview on 6/02/2026 at 11:09 a.m. with RT 3, RT 3 stated oxygen tubing should be changed every seven (7) days to prevent infection.ˆˆ During a concurrent interview and record review on 6/1/2026 at 10:37 a.m. with RT 1, the Respiratory Tasks and Services Equipment Change List (RTSECL), revised 3/26/2024 was reviewed. The RTSECL indicated the oxygen tubing change should be done on Mondays during night shift and as needed. During a review of the facility's Policy and procedure titled Oxygen Administration, reviewed on 4/23/2026, the P&P indicated the purpose of this procedure is to provide guideline for safe oxygen administration. Review Resident care plan to provide the special needs of the Resident, oxygen therapy is administered by way of an oxygen mask, nasal cannula, and /or nasal catheter. Nasal catheter tube is changed and dated every 7 days and as needed. c. During a reviewˆResident 5's admission Record, the admission Recordˆindicated the facility originally admitted Resident 5 on 6/23/2021 and re-admitted ˆthe residentˆon 7/12/2024, with diagnoses including but not limited to tracheostomyˆ(a surgical opening in the neck to insert a breathing tubeˆallowingˆair and oxygen into the lungs), chronic respiratory failureˆ(COPD-a chronic lung disease causingˆdifficulty in breathing), and nontraumatic intracerebral hemorrhageˆ(bleeding into the brain tissue without head injury).ˆ During a review of Resident 5's History and Physical (H&P), dated 12/15/2025, the H&PˆindicatedˆResident 5 does not have the capacity to understand and make decisions.ˆ ˆ During a review of Resident 5's MDS, the MDS indicated Resident 5's cognitive skills (mental abilities that enable a person to think, learn, remember, and solve problems) were severely impaired.ˆ (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ˆ During a review of Resident 5's Physician Order, datedˆ7/13/2024, the Physician Orderˆindicatedˆan for oxygen at four liters (L/min) every shift through the ventilator.ˆ During an observation on 6/1/2026 at 9:54 a.m. in Resident 5's room,ˆResident 5 was in bed receiving oxygen through the ventilator at four L/min. The oxygen tubing was dated 5/18/2026.ˆ ˆ During aˆconcurrent observation andˆinterview on 6/1/2026 at 10:25 a.m. with RT 1, RT 1ˆstatedˆthe oxygen tubing should be changed once a week on Mondays during night shift. RT 1ˆstatedˆResident 5's oxygen tubing should have been changed on 5/25/2026. RTˆ 1 stated if oxygen tubing is not changed for weeks, it could cause respiratory infections, ˆ During a concurrent interview and record review onˆ6/1/2026 at 10:37 a.m. with RT 1, theˆRespiratory Tasks and Services Equipment Change Listˆ(RTSECL), revised 3/26/2024 was reviewed. TheˆRTSECL indicated the oxygen tubing change should be done on Mondays at night shift and as needed.ˆ During a review of the facility's policy and procedure (P&P) titled, SNF Clinic Oxygen Administration, non-dated, the P&P indicated the purpose of the procedure is to provide guidelines for safe oxygen administration, and nasal catheter tubing should be changed and dated every seven days or as needed. Duringˆaˆreview of Residentˆ7'sˆadmission Record, theˆadmission Recordˆindicated the facility originally admitted Residentˆ7ˆonˆ6/16/2022ˆand re-admitted ˆtheˆresident on 1/14/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen),ˆCOPD, andˆhypertension (high blood pressure).ˆˆ ˆ During a record review of Resident 7's H&P, dated 12/15/2025, the H&P indicated Resident 7 does not have the capacity to understand and make decisions. During a review of Resident 7's MDS, dated [DATE], the MDS indicated Resident 7's cognitive skills were severely impaired.ˆ ˆ During a review of Residentˆ7's Order Summary Report, datedˆ6/1/2026, the Order Summary Reportˆindicatedˆan order, dated 1/14/2024, for oxygen atˆfour L/minˆas tolerated.ˆ ˆ Duringˆaˆreview of Residentˆ48'sˆadmission Record, theˆadmission Recordˆindicated the facility originally admitted Residentˆ48ˆonˆ4/29/2025ˆand re-admitted ˆtheˆresident onˆ5/16/2024, with (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses including acute respiratory failure, type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), andˆsepsisˆ(a life-threatening blood infection).ˆ ˆˆ During a review of Residentˆ48's MDS, dated [DATE],ˆtheˆMDSˆindicatedˆResidentˆ48's cognitive skillsˆwereˆseverely impaired.ˆThe MDS indicated Resident 48 receiving oxygen therapy.ˆˆ ˆˆ During a review of Residentˆ48's Order Summary Report dated 6/1/2026, the Order Summary Reportˆindicatedˆan order, datedˆ5/15/2026, for oxygen at four L/min.ˆ ˆˆ During a concurrent observation and interview on 6/1/2026 at 10:08 a.m., withˆRespiratory Therapistˆ(RT)ˆ2, inside Resident 48's room, Resident 48 wasˆobservedˆin bed receiving oxygen from the oxygen concentrator at four L/min.ˆObservedˆResident 48's oxygen tubing dated 5/18/2026.ˆRT 2ˆstated oxygen tubing should be changed every seven days to help prevent infection. RTˆ2ˆstated oxygen tubing should have been changed on 5/25/2026 and as needed.ˆ ˆ During a concurrent observation and interview on 6/1/2026 at 10:12 a.m., with RT 2, inside Resident 7's room, Resident 7 was observed in bed receiving oxygen from the oxygen concentrator at four L/min. Observed Resident 7's oxygen tubing and oxygen humidifier (a device thatˆadds moisture to supplemental oxygen before it's delivered to your airway) was dated 5/18/2026.ˆRT 2ˆstatedˆfacility standard policy is to changeˆoxygen tubingˆevery 7ˆdays and asˆneeded.ˆRT 2ˆstatedˆResident 7 oxygen tubingˆshould have been changed on 5/25/2026 and asˆneeded.ˆˆ During a concurrent interview and record review on 6/02/2026 at 11:05 a.m. with Director of Nursing (DON), the policy and procedure (P&P) titled, SNF Clinic Oxygen Administration reviewed on 4/23/2026, was reviewed. The DONˆstated theˆfacility reviewed the P&P on 4/23/2026, the facility follows this P&P andˆdoes not have anˆadditionalˆpolicyˆregardingˆthe replacement of oxygen therapy equipment. The DONˆstatedˆaccording to the current policy, oxygen tubingˆshouldˆbe dated and replaced every sevenˆdays andˆas needed to prevent infection.ˆ ˆ During a concurrent interview on 6/02/2026 at 11:09 a.m. with RTˆ3,ˆRT 3ˆstated oxygen tubing should be changed every seven days to prevent infection.ˆˆˆ ˆ During a review of the facility's Policy and procedure titled Oxygen Administration, reviewed on 4/23/2026, the P&Pˆindicatedˆthe purpose of thisˆprocedure is to provideˆguidelineˆfor safe oxygen administration.ˆReviewˆResidentˆcare plan to provide the specialˆneeds ofˆtheˆresident,ˆoxygen therapy isˆadministeredˆby way of an oxygen mask, nasalˆcannula,ˆand /or nasal catheter. Nasal catheterˆtubeˆis changed and dated every 7 days and as needed.ˆ

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to: 1. Have an available supply of bumetanide (a medication used for congestive heart failure [CHF] - condition where the heart does not pump blood efficiently to the rest of the body) in the facility affecting 1 (one) of five (5) observed residents (Resident 41) for medication administration. As a result, medication administration and availability of medications did not follow facility policy and procedures, resulting in Resident 41 not receiving bumetanide on 6/2/2026 for the 9 a.m. dose. 2. Reconcile (the process of comparing transactions and activity to supporting documentation) one (1) medication eKIT containing controlled medications (also known as Controlled Drug and Controlled Substance [CM, CD, CS]- medications which have a potential for abuse and may also lead to physical or psychological dependence) for June 2026, in one (1) of two (2) inspected Medication Rooms (Medication Room Subacute.) As a result, control and accountability of CM did not follow state and federal regulations and facility policy and procedures. 3. Include the verifying signatures of two (2) licensed nurses on the Medication Disposition Record/Pass logs observed in Medication Room Subacute for two (2) of two (2) sampled records. As a result, control and accountability of medication disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures. 4. Dispose of medications in a manner that was not retrievable (able to get back,) in one (1) of two (2) inspected Medication Rooms (Medication Room Subacute.) As a result, control and accountability of medications awaiting final disposition (process of returning and/or destroying unused medications) did not follow state and federal regulations and facility policy and procedures. These failures had the potential to result in Resident 41 receiving suboptimal (less than standard) care, experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have), and in Residents 41's health and well-being to be negatively impacted. In addition, these failures had the potential in increasing the opportunity for medication diversion (the transfer of medications from a lawful to an unlawful channel of distribution or use,) including CM diversion, and the risk that residents in the facility could have accidental exposure to harmful medications possibly leading to physical and psychosocial harm, hospitalization and death. Findings: During an observation on 6/2/2026 at 9:18 a.m., in Medication Cart 1, Licensed Vocational Nurse (LVN) 6 was observed administering amiodarone (a medication used to control irregular heart rate), ferrous sulfate (a supplement), ascorbic acid (a supplement), levetiracetam (a medication used to prevent seizures), nephro-vite (a supplement), and zinc (a supplement) via gastrostomy tube ([G-tube] - a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 41. LVN 6 was not observed administering bumetanide via G-tube to Resident 41. During an interview on 6/2/2026 at 11:25 a.m., with LVN 6, LVN 6 stated LVN 6 administered several medications to Resident 41 and did not administer bumetanide that day (6/2/2026) at 9:18 a.m. to Resident 41, as prescribed by Resident 41's physician, since bumetanide was not available in Medication Cart 1 or the facility. LVN 6 stated that medications should be readily available to ensure timely administration at the scheduled times. LVN 6 stated that medications should be ordered seven (7) days in advance of last dose and followed up with pharmacy to prevent missing doses. LVN 6 stated bumetanide was a medication used for CHF and not administering and missing a dose could harm Resident 41 by increasing the risk of fluid buildup in the legs and lungs causing difficulty in breathing, potentially leading to hospitalization. LVN 6 stated facility failed to ensure bumetanide was readily available in Medication Cart 1 and facility at time of scheduled dose, resulting in Resident 41 not receiving a dose one (1) hour before to one (1) hour after the 9 a.m. scheduled dose. LVN 6 stated LVN 6 followed up with pharmacy to expedite the refill of bumetanide and notified Resident 41's physician that the morning dose was not administered and instructed to complete a Change of Condition assessment. During a concurrent observation, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record review and interview on 6/2/2026 at 12 p.m., with Registered Nurse (RN) 2, in Medication Room Subacute there was: 1. One (1) medication eKIT stored in the refrigerator containing CMs, labeled REF232, without an accountability log for the reconciliation of CM inventory at every shift change for June 2026. 2. Two (2) Medication Disposition Record/Pass logs, dated 5/31/2026 and signed by RN 4, without witness initials for the destruction of eight (8) medications listed on the form. RN 2 reviewed two (2) Medication Disposition Record/Pass logs dated 5/31/2026. RN 2 stated RN 2 was unable to locate the signatures/initials or names of a witness on the two (2) logged disposition records. RN 2 stated that RN 4 failed to follow facility policy of signing the logs with a licensed nurse as a witness, when RN 4 disposed of the medications on 5/31/2026. RN 2 stated that all CMs, including medication eKITs containing CMs, should be reconciled at every shift. RN 2 stated that the eKIT labeled REF232 in the refrigerator of Medication Room Subacute contained CMs and was not reconciled at every shift in June 2026. RN 2 stated it was important to account for all CMs to ensure accountability, prevent CM diversion and accidental exposure of harmful substances to residents. During a concurrent observation and interview on 6/2/2026 at 2 p.m., with Registered Nurse (RN) 2 in Medication Room Subacute, a red plastic waste bin was observed to contain a mixture of intact (unchanged from original form) orange plastic bottles containing liquids, medication bottles, packages and bubble packs (medication packaging system that contains individual doses of medication per bubble) containing medications. RN 2 stated, per facility policy and procedures, medications needed to be disposed of in a manner that the medications could not be retrieved intact by removing the individual medications from the bubble packs, packages and bottles, and pouring water over them to disintegrate (break apart) the medications. RN 2 stated the red waste bin did not contain any water or liquid to disintegrate the medications, and the medications remained in their original form, allowing for easy access, retrieval and for potential re-use. RN 2 stated not disposing medications properly increased the potential for accidental misuse and diversion. During a concurrent interview and record review on 6/4/2026 at 10:56 a.m., with the Director of Nursing (DON,) the DON stated per facility policies, medications should be ordered five (5) days in advance and be readily available in the facility for administration of doses at their scheduled times as prescribed. The DON stated that LVN's were expected to re-order medications timely and follow-up with pharmacy on the refills to ensure medications were available to residents. The DON stated that LVN 6 failed to administer bumetanide to Resident 41 at the time scheduled by Resident 41's physician, since the medication was not readily available, placing Resident 41 at risk of fluid buildup in the legs and lungs with the dose omission. The DON stated several licensed nurses failed to follow policy and procedures for medication reordering resulting in unavailability and interruption of medication administration and continuity of care for Resident 41. The DON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated the eKIT containing CMs in Medication Room Subacute labeled REF232 was not reconciled at each shift change in June 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKIT at each shift change in Medication Room Station Subacute. The DON reviewed the two (2) Medication Disposition Record/Pass logs dated 5/31/2026. The DON stated the DON was unable to locate the witness initials on the logs. The DON stated RN 4 failed to include the initials of a licensed nurse witness when destroying medications on 5/31/2026. The DON stated it was important to verify and sign these logs with witnesses to prevent medication diversions and accidental exposure to residents. The DON stated per facility policy and procedures, medications needed to be disposed of in a manner that the medications could not be retrieved intact by removing them from their packaging and pouring water in the waste bine to disintegrate the medications. The DON acknowledged the red waste bin contained medications that were disposed in their original manufacturer containers, bottles and bubble packs and the bin did not contain water poured over the medications, the mediations remained in their original form, allowing for easy access, retrieval, and potential re-use. The DON acknowledged that without proper disposal of medications (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was increased risk and potential of accidental misuse and diversion of medication, and exposure of harmful substances affecting the safety of all residents in the facility. The DON stated the facility failed to destroy the medications found in the red plastic waste bin in Medication Room Subacute safely and according to facility policy and state regulations. During a concurrent interview and record review on 6/4/2026 at 10:56 a.m., with the Director of Nursing (DON,) the DON stated per facility policies, medications should be ordered five (5) days in advance and be readily available in the facility for administration of doses at their scheduled times as prescribed. The DON stated that LVN's were expected to re-order medications timely and follow-up with pharmacy on the refills to ensure medications were available to residents. The DON stated that LVN 6 failed to administer bumetanide to Resident 41 at the time scheduled by Resident 41's physician, since the medication was not readily available, placing Resident 41 at risk of fluid buildup in the legs and lungs with the dose omission. The DON stated several licensed nurses failed to follow policy and procedures for medication reordering resulting in unavailability and interruption of medication administration and continuity of care for Resident 41. The DON stated that medication eKITs containing CMs needed to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated the eKIT containing CMs in Medication Room Subacute labeled REF232 was not reconciled at each shift change in June 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKIT at each shift change in Medication Room Station Subacute. The DON reviewed the two (2) Medication Disposition Record/Pass logs dated 5/31/2026. The DON stated the DON was unable to locate the witness initials on the logs. The DON stated RN 4 failed to include the initials of a licensed nurse witness when destroying medications on 5/31/2026. The DON stated it was important to verify and sign these logs with witnesses to prevent medication diversions and accidental exposure to residents. The DON stated per facility policy and procedures, medications needed to be disposed of in a manner that the medications could not be retrieved intact by removing them from their packaging and pouring water in the waste bine to disintegrate the medications. The DON acknowledged the red waste bin contained medications that were disposed in their original manufacturer containers, bottles and bubble packs and the bin did not contain water poured over the medications, the mediations remained in their original form, allowing for easy access, retrieval, and potential re-use. The DON acknowledged that without proper disposal of medications there was increased risk and potential of accidental misuse and diversion of medication, and exposure of harmful substances affecting the safety of all residents in the facility. The DON stated the facility failed to destroy the medications found in the red plastic waste bin in Medication Room Subacute safely and according to facility policy and state regulations. During a review of Resident 41's admission Record (a document containing demographic and diagnostic information,) dated 6/2/2026 the admission Record indicated Resident 41 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including peripheral vascular angioplasty with implants and grafts (a procedure used to treat blocked or narrowed blood vessels outside of the heart.) During a review of Resident 41's Order Summary Report (a report listing the physician order for the resident,) dated 6/2/2026, the report indicated Resident 41 was prescribed: -Bumetanide 0.5 milligram ([mg] - a unit of measure of mass) tablet, to give via G-tube once a day for CHF, starting 4/30/2026. During a review of Resident 41's ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for June 2026, the MAR indicated Resident 41 was prescribed: -Bumetanide 0.5 mg tablet via G-tube once a day for CHF, to be given at 9 a.m. During a review of the facility's Policy and Procedures (P&P,) titled Medication Administration -General Guidelines, last reviewed 4/3/2026, the P&P indicated: Medications are administered as prescribed in accordance with good nursing principles and practices. 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before to 1 hour after.) During a review of the facility's P&P titled Controlled Medication Storage, last reviewed 4/3/2026, the P&P indicated: D. At each shift (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change, a physical inventory of all controlled medications, including the emergency supply is conducted by two (2) licensed nurses and is documented on the controlled medication accountability record. During a review of the facility's P&P titled Ordering and Receiving Medications from the dispensing Pharmacy, last reviewed 4/3/2026, the P&P indicated: Medications and related products are received from the dispensing pharmacy on a timely basis. 2.a. Reorder medications five (5) days in advance of need to assure an adequate supply is on hand. During a review of the facility's P&P, titled Medication Destruction, last reviewed 4/3/2026, the P&P indicated: C. Non-controlled mediation destruction occurs in the presence of two (2) licensed nurses. D. The nurse(s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form. 6. signatures of witnesses. During a review of the P&P titled Discarding and Destroying Medications, last reviewed 4/3/2026, the P&P indicated: Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. 3. Non-controlled and Schedule V (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. a. Take the medication out of the original containers. b. Mix medication, either liquid or solid, with an undesirable substance. 11. The medication disposition record will contain the following information: Signature of witnesses.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure residents who receive heparin (an anticoagulant [a blood thinner that treats and help prevents blood clots]) were monitored for potential side effects (unintended, undesirable effect of a medication or medical treatment) as indicated in the physician's orders for one of five residents (Resident 48) reviewed for unnecessary medications. This failure placed Resident 48 at risk for undetected side effects, potentially resulting in life-threatening complications. Findings: Duringˆaˆreview of Residentˆ48'sˆadmission Record, the admission Recordˆindicated the facility originally admitted Resident 48ˆon 4/29/2025ˆand re-admitted ˆtheˆresident on 5/16/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), type II diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), and sepsis (a life-threatening blood infection). During a review of Residentˆ48's Minimum Data Set (MDS-a resident assessment tool), datedˆ2/27/2026,ˆthe MDS indicated Residentˆ48's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated that Resident 48 was receiving an anticoagulant. During a review of Resident 48's Physician Order Summary Report, active orders as of 5/16/2026, the Physician Order Summary Report indicated the following orders: -Heparin Sodium Injection Solution 5000-unit per milliliters (u/mL-measures the concentration of a substance within a specific volume of liquid) Inject 5000 unit subcutaneously (under the skin) one time a day for deep vein thrombosis (DVT) a serious condition where a blood clot forms in a deep vein, prophylaxis(prevention) -Anticoagulant Heparin Medication Monitoring: Monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds. During a concurrent interview and record review on 6/2/2026 at 10:50 a.m. with Director of Nursing (DON), Resident 48's Electronic Medication Administration Record (eMAR) dated 5/17/2026 to 5/31/2026 was reviewed. ˆThe DON stated Resident 48's MAR indicated Resident 48 received heparin injections from 5/17/2026 to 5/31/2026. ˆThe DON stated heparin is an anticoagulant and can cause major and serious bleeding. ˆThe DON stated licensed nurses should monitor and document the side effects of heparin in the eMAR. ˆThe DON reviewed Resident 48's eMAR dated 5/17/2026 to 5/31/2026. Theˆ DON stated there was no documentation in the eMAR to indicate that licensed nurses were monitoring Resident 48 for side effects such as bleeding associated with anticoagulant therapy. The DON stated regular monitoring of residents who are on anticoagulant medications allows licensed nurses to identify early signs and symptoms of bleeding promptly and notify the physicians for timely evaluation and intervention to prevent harm.to residents.ˆThe DON further stated that the was a physician order to monitor Resident 48 for side effect of heparin use such as discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle joint pain, lethargy, bruising, sudden changes in mental status and or vital signs, shortness of breath, nose bleeds, which was not followed. During an interview and record review on 6/3/2026 at 3:40 p.m. with the Minimum Data Set Nurse (MDS) Nurse, Resident 48's eMAR dated 5/17/2026 to 5/31/2026 was reviewed. ˆThe MDS Nurse stated Resident 48's eMAR indicated Resident 48 received heparin injections from 5/17/2026 to 5/31/2026 and licensed nurses should monitor and document the side effects associated with heparin use in the eMAR. ˆTheˆMDS Nurse stated there was no documentation in the eMAR to indicate that licensed nurses were monitored Resident 48 for side effects associated with heparin use, such as bleeding. The MDS stated regular monitoring of the residents allows licensed nurses to identify early signs and symptoms of bleeding promptly and notify the physician so that appropriate interventions can be implemented to prevent harm to residents.ˆ During a review of the facility's policy and procedure (P&P) titled Anticoagulation - Clinical Protocol, reviewed 4/23/ 2026, the P&Pˆindicatedˆthe staff, and physician will monitor for possible complications in individuals who (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are being anticoagulated and will manage related problems. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant. The physician will order measures to address any complications, including holding or discontinuing the anticoagulant as indicated.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Two (2) medication errors out of 32 total opportunities contributed to an overall medication error rate of 6.25% affecting two (2) of five (5) residents observed for medication administration (Resident 41 and 74.) The medication errors were as follows: 1. Resident 41 did not receive bumetanide (a medication used for congestive heart failure [CHF] - condition where the heart doesn't pump blood efficiently to the rest of the body) as ordered by Resident 41's physician. 2. Resident 74 was to be administered crushed (a medication turned to soft powder) metoprolol succinate ER 24-hour (a slow-release medication used for high blood pressure throughout a 24-hour period) tablet. These failures had the potential to result in Resident 41 and 74 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have,) and health complications such as stomach irritation, ineffective blood pressure control and buildup of fluids into legs and lungs, resulting in Resident 41 and 74's health and well-being to be negatively impacted. Findings: During an observation on 6/2/2026 at 9:18 a.m., in Medication Cart 1, Licensed Vocational Nurse (LVN) 6 was observed administering amiodarone (a medication used to control irregular heart rate,) ferrous sulfate (a supplement,) ascorbic acid (a supplement,) levetiracetam (a medication used to prevent seizures,) nephro-vite (a supplement,) and zinc (a supplement) via gastrostomy tube ([G-tube] - a tube inserted through the belly that brings nutrition directly to the stomach) to Resident 41. LVN 6 was not observed administering bumetanide via G-tube to Resident 41. During an interview on 6/2/2026 at 11:25 a.m., with LVN 6, LVN 6 stated LVN 6 administered several medications to Resident 41 and did not administer bumetanide that day (6/2/2026) at 9:18 a.m. to Resident 41, as prescribed by Resident 41's physician, since bumetanide was not available in Medication Cart 1 or the facility. LVN 6 stated this omission (exclusion) was considered a medication error. LVN 6 stated that medications should be readily available to ensure timely administration at the scheduled times. LVN 6 stated bumetanide was a medication used for CHF and not administering and missing a dose could harm Resident 41 by increasing the risk of fluid buildup in the legs and lungs causing difficulty in breathing, potentially leading to hospitalization. LVN 6 stated facility failed to ensure bumetanide was readily available in Medication Cart 1 and facility at time of scheduled dose, resulting in Resident 41 not receiving a dose one (1) hour before to one (1) hour after the 9 a.m. scheduled dose. During an observation on 6/3/2026 at 9:20 a.m., in Medication Cart 1, LVN 3 was observed crushing (pressing very hard so that the shape is destroyed and forms a soft powder) metoprolol succinate ER 24-hour tablet and mixing with applesauce for oral administration to Resident 74. During an observation on 6/3/2026 at 9:35 a.m., LVN 3 was observed handing Resident 74 a spoonful of applesauce containing metoprolol succinate ER 24-hour crushed powder. LVN 3 was stopped by the surveyor before the applesauce mixture containing metoprolol succinate ER 24-hour powder was administered to Resident 74 and advised discussing the medication preparation with the surveyor in the hallway. During an interview, on 6/3/2026 at 9:40 a.m., with LVN 3, LVN 3 stated that LVN 3 crushed metoprolol succinate ER 24-hour tablet and acknowledged that LVN 3 should not have crushed it. LVN 3 stated this was considered a medication error. LVN 3 stated that metoprolol succinate ER 24-hour tablet was a slow-release tablet and intended to be administered whole and slowly released in the stomach to prevent stomach irritation and provide the dose throughout the day. LVN 3 stated crushing the tablet makes the release of the medication immediate instead of slow. LVN 3 stated administering crushed metoprolol succinate ER 24-hour tablet could result in adverse reactions for Resident 74 such as stomach irritation and uncontrolled blood pressure. LVN 3 stated that LVN 3 failed to follow standard of practice and facility policy and procedures (P&P) for the administration of slow-release medications. During an interview on 6/4/2026 at 10:56 a.m., with the Director of Nursing (DON), the DON stated per facility policy, medications (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be administered within a 60-minute window from the time scheduled, and that there should be adequate supply of medications on hand for continuity of care. The DON stated that LVN 6 failed to administer bumetanide to Resident 41 at the time scheduled by Resident 41's physician, since the medication was not readily available, placing Resident 41 at risk of fluid buildup in the legs and lungs with the dose omission. The DON stated this was considered a medication error. The DON stated several licensed nurses failed to follow facility P&P for medication reordering resulting in unavailability and interruption of medication administration and continuity of care for Resident 41. During the same interview, the DON stated as a standard of practice nurses should not crush slow-release medications to prevent altering the delivery time of the medication. The DON stated that slow-release medications, such as ER tablets, should not be crushed. The DON stated doing so will make the medication immediate release and cause adverse effects. The DON stated LVN 3 failed not to crush metoprolol succinate ER 24-hour tablet that day (6/3/2026) during morning medication administration, increasing the risk of medication adverse effects, such as stomach irritation and inadequate blood pressure control for Resident 74. The DON stated this was also considered a medication error. During a review of Resident 41's admission Record (a document containing demographic and diagnostic information,) dated 6/2/2026 the admission Record indicated Resident 41 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with diagnosis including peripheral vascular angioplasty with implants and grafts (a procedure used to treat blocked or narrowed blood vessels outside of the heart.) During a review of Resident 41's Order Summary Report (a report listing the physician order for the resident,) dated 6/2/2026, the report indicated Resident 41 was prescribed: -Bumetanide 0.5 milligram ([mg] - a unit of measure of mass) tablet, to give via G-tube once a day for CHF, starting 4/30/2026. During a review of Resident 41's ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for June 2026, the MAR indicated Resident 41 was prescribed: -Bumetanide 0.5 mg tablet via G-tube once a day for CHF, to be given at 9 a.m. During a review of Resident 74's admission Record dated 6/3/2026 the admission Record indicated Resident 74 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including HTN. During a review of Resident 74's Order Summary Report dated 6/3/2026, the report indicated Resident 74 was prescribed: Metoprolol succinate ER 24-hour 50 mg tablet to give orally once a day for HTN, starting 12/10/2025. May crush crushable meds, starting 12/9/2025. During a review of Resident 74's MAR for June 2026, the MAR indicated Resident 74 was prescribed: Metoprolol succinate ER 24-hour 50 mg one (1) tablet orally once a day for HTN, to be given at 9 a.m. During a review of the facility's P&P titled Medication Administration-General Guidelines, last reviewed 4/3/2026, the P&P indicated that Medications are administered as prescribed in accordance with good nursing principles and practices. Preparation 5. if it safe to do so, medication tablets may be crushed.using the following guidelines. a. slow release . dosage forms should generally not be crushed; an alternative should be sought. Administration 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after.) During a review of the facility's P&P, titled Medication Crushing Guidelines, last reviewed 4/3/2026, the P&P indicated: The solid dosage forms of medications should not be crushed or chewed for a variety of reasons. The nurse administering the medication should check to see that there are no contraindication to crushing the medications in question. The rationale for not crushing some medications includes: D. Timed release tablets are designed to release medication over sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed. Some specific types of timed-release tablets include the following: 1) slow release core. During a review of the facility's provided reference guide, titled DO NOT CRUSH LIST, last reviewed 4/3/2026, the guide indicated: metoprolol succinate tablet is slow-release. During a review of the facility's P&P, titled Medication Errors, last reviewed 4/3/2026, the P&P indicated: b. Medication Error means the administration of medication: At the wrong time Via wrong route.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility staff failed to secure the keys for one of three medication carts (Medication Cart 2), leaving the keys unattended and allowing unauthorized access to the cart and its contents, including but not limited to Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs). This deficient practice placed residents at risk for unauthorized access to medications, including controlled substances, which could result in medication diversion, misuse, overdose, theft, delayed administration of prescribed medications, and potential harm to residents. Findings: ˆ During an observation on 6/1/2026 at 10:18 a.m, next to Nursing Station 1, on top of Medication Cart 2 , four keys were observed left unattended on top of Medication Cart 2, attached to a key ring labeled Med Cart 2. Findings: ˆ During an observation on 6/1/2026 at 10:18 a.m, next to Nursing Station 1, on top of Medication Cart 2 , four keys were observed left unattended on top of Medication Cart 2, attached to a key ring labeled Med Cart 2. ˆˆ During a concurrent observation and interview on 6/1/2026 at 10:20 a.m., with Registered Nurse 3 (RN 3), next to Nursing Station 1, four keys were observed left unattended on top of Medication Cart 2, attached to a key ring labeled Med Cart 2 , were observed. RN 3 stated that the four keys that were left unattended on top of Med Cart 2 were handed to her at the beginning of her shift on 6/1/2026 at around 7 a.m., and she was responsible for the keys. RN 3 stated the keys belonged to Medication Cart 2 and provided access to the Medication Cart 2's lock. RN 3 further stated that the contents of Medication Cart 2 included, but were not limited to, controlled and noncontrolled medications (drugs that do not have a high potential for abuse or dependence and are not regulated by Federal agencies), as well as over-the-counter medications. RN 3 stated she forgot and left the keys on top of Medication Cart 2. RN 3 stated that, according to facility policy, all residents' medications-both controlled and noncontrolled-must be kept in a locked drawer. RN 3 stated the keys must remain with her at all times because leaving them unattended could allow residents, or staff to access the contents of the medication cart, creating the potential for medication diversion, especially involving controlled medications. RN 3 further stated that residents could take the medications, which could result in harm to them. During an interview on 6/2/2026 at 12:12 p.m. with the Director of Nursing (DON),ˆthe DON stated the facility keeps residents' medications-controlled, noncontrolled, and emergency kit (Ekit) medications-over the counter medication in the medication cart in locked drawers. The DON stated the keys to the medication cart must remain with licensed staff at all times to prevent staff or residents from accessing the medications, which could lead to theft, misuse, or potential harm. The DON stated licensed nurse should have not left the key unattended on the cart. During aˆreview of facility's policy and procedure (P&P) titled, Storage of Medications, revised onˆ4/23/2026, the P&P indicatedˆonly persons authorized to prepare and administer medications have access to locked medications. During aˆreview of facility's policy and procedure (P&P) titled, Controlled Substances, revised onˆ4/23/2026, the P&P indicatedˆthe facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule 11-V of the Comprehensive Drug Abuse.) Only authorized licensed nursing and/or pharmacy personnel have access to Schedule II controlled substances maintained on premises. The charge nurse on duty maintains the keys to controlled substance containers. ˆ ˆ

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure safe and sanitary food storage and distribution practices when:A case of thickened dairy drink was served beyond the printed best by date.A bag of dry pasta was stored without a seal or closure. A utensil scoop store inside container of white flour. These deficient practices 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 toxins) in 55 of 89 residents who received food from the facility kitchen.During an observation in the walk-in refrigerator in the facility's kitchen on 06/01/26 at 8:48 AM, a half-full carton of thickened dairy drink (a specialized milk-based drink that flows more slowly used to prevent choking and aspiration in patients with swallowing difficulty or disorders) had a printed best by date of 05/27/26. The carton had a 5/22 written in a black marker on the top near the best by date and had Open 6/1/26 on the long side of the carton. During continued observation in a separate area within the walk-in refrigerator, five more unopened cartons of thickened dairy drink with best by dates of 05/27/26 and written 5/22 in black marker on the tops were observed. During a concurrent interview with the Dietary Supervisor (DS), the DS confirmed that the 5/22 dates were written by kitchen staff to denote the facility's received date of the product. The DS also stated that the dairy drink should not be served and discarded since bacteria could grow in it. The DS stated the DS usually checks best by and expiration dates upon receiving food shipments, however, could not do so while she was on leave. During a document review of the 2022 FDA Food Code, Annex 3 section 3-501.18, the Food Code indicated that the time/temperature control for safety of refrigerated foods must be consumed, sold or discarded by the expiration date.During an observation in dry food storage in the facility's kitchen on 06/01/26 at 9:05 AM, an open bag of dry pasta was resting on a rack alongside several unopened bags of pasta. The bag had no seal or enclosure. During a concurrent interview, the DS stated that the pasta should be in a tight container to protect from potential contamination citing a risk for physical or biological contamination including pests. During a document review of the 2022 FDA Food Code, section 3-305.11, the Food Code indicated that food shall be protected from contamination by storing the food where it is not exposed to splash, dust, or other contamination.During a document review of the facility's policy titled Food Storage: Dry Goods dated 02/2023, the policy indicated that all packaged food items will be kept clean, dry, and properly sealed. During an observation in dry food storage in the facility's kitchen on 06/01/26 at 9:05 AM, a large white bulk food container lined with plastic contained inside a 50 pounds (lb.-unit of weight) brown paper bag of white flour, torn open at the top, and a large metal scoop with remnants of flour on the scoop and surrounding area on the bottom of the container. During a concurrent interview, the DS stated that the scoop should not be kept inside the container alongside food between use since it poses a risk for contamination as the scoop is handled by kitchen staff. The DS stated that their scoop storage on the wall is in disrepair and should be kept within a sealable bag in the interim. During a document review of the 2022 FDA Food Code, section 3-304.12, it indicated that dispensing utensils between-use shall be stored in a clean, protected location. The FDA Food Code further indicated in Annex 3 section 3-304.12 that a food utensil should be used to prevent bare hand contact or minimize contact with food that is not in a ready-to-eat form.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to provide care in a manner that maintained a resident`s dignity and respect by failing to ensure Certified Nursing Assistant 1 (CNA 1) knocked prior to entering a resident`s room for one ofˆoneˆresident (Residentˆ92) reviewed under the dignity care area. This deficient practice violated the resident's right to be treated with respect and dignity and had the potential to affect Residentˆ92`s sense of self-worth and self-esteem.ˆ Findings:ˆ During a review of Residentˆ92's admission Record (AR), theˆadmission recordˆindicatedˆthe facilityˆadmitted the resident onˆ1/24/2025ˆwith diagnoses including,ˆparaplegia (a medical condition characterized by the partial or complete loss of motor and sensory function in the lower half of the body) andˆgastro-esophageal reflux disease (stomach acid flows back up into the esophagus and causes heartburn).ˆˆ During a review of Resident 92's Minimum Data Set (MDS-a resident assessment tool) datedˆ5/08/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 92 requiredˆsubstantial/maximalˆassistanceˆ(helper does more than effort)ˆfor toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent observation and interview on 6/01/2026 at 11:11 a.m. with Licensed Vocational Nurse 1 (LVN 1) in the hallway across Resident 92`s room, observed Certified Nurse Assistant 1 enter Resident 92`s room without knocking and asking permission before entering the resident`s room. LVN 1 stated CNA 1 should have knocked and asked permission before entering the resident`s room. LVN 1 stated that all staff should respect residents' privacy by asking permission or consent before entering their rooms. During an interview on 6/01/2026 at 11:29 a.m., with CNA 1, CNA 1 stated that LVN 1 spoke to her regarding entering Resident 92`s room without knocking or asking permission to enter. CNA 1 stated she should have asked Resident 2's permission before entering to show respect for the resident's privacy and rights. During a review of the facility`s policy and procedure (P&P) titled Dignity, last reviewed onˆ4/23/2026, the P&P indicated that Each resident shall be cared forˆin a manner that promotes and enhancesˆindividuality, aˆsense of well- being,ˆˆsatisfaction with life, and feeling of self-worth and self-esteem.staff are expected to knock and request permission before enteringˆresidents` rooms.ˆ

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide one of three sampled residents (Resident 32), a safe, clean, comfortable, and homelike environment when the facility failed to ensure Resident 32's living area was kept clean and clutter-free.This failure had the potential to make the resident feel uncomfortable and place the resident at increased risk for accidents and infections. Findings: During a review of Resident 32's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicatedˆthe facilityˆoriginallyˆadmitted ˆResident 32ˆto the facilityˆon 1/29/2026ˆandˆreadmitted on [DATE] with diagnoses includingˆbut not limited to metabolic encephalopathy (brain dysfunction caused by chemical imbalances), pneumonia (an infection/inflammation in the lungs), and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of the Minimum Data Set (MDS - a resident assessment tool), datedˆ5/22/2026, the MDS indicated Resident 32 had moderate impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses), and required eating clean-up assistance. During an observation on 6/1/2026 at 11:35 a.m. in Resident 32's room, there were brown food crumbs, dry spilled liquids, and an undated cup with milk on Resident 32's bedside table; a bundle of disposable gloves and four sugar packets spread on the floor on the right side of Resident 32's bed. ˆ During a concurrent observation and interview on 6/1/2026 12:10 p.m. with Certified Nursing Assistant 2 (CNA 2) in Resident 32's room, CNA 2 looked at Resident 32's bedside table and floor. CNA 2 stated the sugar packets, used gloves, and bedside table should have been cleaned, if the milk was out too long and Resident 32 drank it, Resident 32 could get sick. CNA 2 stated staff should contact the maintenance team to clean the resident's room. During a concurrent observation and interview on 6/1/2026 at 12:19 p.m. with Licensed Vocational Nurse 3 (LVN 3) in Resident 32's room, LVN 3 looked at Resident 32's bedside table and floor. LVN 3 stated the CNA caring for Resident 32 should maintain the area clean; the food crumbs and floor should have been cleaned up and the milk removed though sometimes Resident 32 refuses to have food or drinks taken away. LVN 3 stated any CNA who sees a resident's room or bedside table that needs cleaning should clean it or call maintenance. During a concurrent observation and interview on 6/1/2026 at 12:48 p.m. with Registered Nurse (RN) 1 in Resident 32's room. RN 1 stated Resident 32's bedside table and floor should have been cleaned. During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, revised February 2021, the P&P indicated the facility staff and management maximize, to the extent possible, a clean, sanitary and orderly homelike environment.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensureˆa resident or their representative participated in the Interdisciplinaryˆ Team (IDT-ˆan interdisciplinary team is a group of health care professionals working collaboratively toward a common goal. This team includes professionals withˆdifferent rolesˆinvolved in treating a patient's condition or diagnosis) care planning process conducted on 11/9/2025ˆfor one of 19 residents (Residentˆ92) reviewed underˆCare Planning.ˆ This deficient practice had the potential to result in Residentˆ92 notˆreceivingˆperson centered careˆ(person-centered careˆallows patients to make informed decisions about their treatment and well-being)ˆtoˆmeet the resident`s needs.ˆˆ Findings:ˆ During a review of Residentˆ92's admission Record, theˆadmission Recordˆindicatedˆthe facilityˆadmitted the resident onˆ1/24/2025ˆwith diagnoses including,ˆparaplegia (a medical condition characterized by the partial or complete loss of motor and sensory function in the lower half of the body) andˆgastro-esophageal reflux disease (stomach acid flows back up into the esophagus and causes heartburn).ˆˆ During a review of Resident 92's Minimum Data Set (MDS-a resident assessment tool) datedˆ5/08/2026, the MDS indicated the resident had the ability to make self-understood and the ability to understand others. The MDS indicated that Resident 92 requiredˆsubstantial/maximalˆassistanceˆ(helper does more than effort)ˆwith toileting hygiene, shower, upper and lower body dressing, putting on/taking off footwear and personal hygiene. Registered Nurse 1 (RN 1) During a concurrent interview and record review on 6/03/2026 at 2:35 p.m., with Registered Nurse 1 (RN 1), reviewed Resident 92's Interdisciplinary Care Conference (ICC) notes dated 11/09/2025. The ICC indicated that the attendees did not include Resident 92 or his representative. RN 1 stated that resident`s involvement in the care planning process during the ICC is important to ensure the resident is given the opportunity to verbalize any concerns and issues regarding his care. RN 1 stated by involving the resident in the care planning process, the IDT can develop a resident-centered care plan that addresses the resident's specific needs, preferences, and goals. RN 1 stated that the quarterly ICC will afford the care team and the resident the opportunity to develop new interventions if the existing care plan goals are not achieved. RN 1 stated that the resident`s needs may not be met if their input is not solicited during the care planning process, resulting in identified problems remaining unresolved. During a review of the facility`s policy and procedure (P&P) titled Care Planning-Interdisciplinary Team, last reviewed on 4/23/2026, the P&P indicated that Our facility`s Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.the resident, the resident`s family and/or the resident`s representative are encouraged to participate in the development of an revisions to the resident`s care plan.

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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. Based on observation, interview and record review, the facility failed to provide care in accordance with professional standards and facility policy and procedures (P&P) for one (1) of five (5) residents (Resident 74) observed for medication administration, by failing to not crush (pressing very hard so that the shape is destroyed and forms a soft powder) metoprolol succinate ER 24-hour (a slow-release medication used for high blood pressure throughout a 24-hour period) tablet. This deficient practice had the potential to result in Resident 74 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have,) and health complications such as stomach irritation, and ineffective blood pressure control resulting in Resident 74's health and well-being to be negatively impacted. Findings: During an observation on 6/3/2026 at 9:20 a.m., in Medication Cart 1, Licensed Vocational Nurse (LVN) 3 was observed crushing (pressing very hard so that the shape is destroyed and forms a soft powder) metoprolol succinate ER 24-hour tablet and mixing with applesauce for oral administration to Resident 74. During an observation on 6/3/2026 at 9:35 a.m., LVN 3 was observed handing Resident 74 a spoonful of applesauce containing metoprolol succinate ER 24-hour crushed powder. LVN 3 was stopped by the surveyor before the applesauce mixture containing metoprolol succinate ER 24-hour powder was administered to Resident 74 and advised discussing the medication preparation with the surveyor in the hallway. During an interview, on 6/3/2026 at 9:40 a.m., with LVN 3, LVN 3 stated that LVN 3 crushed metoprolol succinate ER 24-hour tablet and acknowledged that LVN 3 should not have crushed it. LVN 3 stated that metoprolol succinate ER 24-hour tablet was a slow-release tablet and intended to be administered whole and slowly released in the stomach to prevent stomach irritation and provide the dose throughout the day. LVN 3 stated crushing the tablet makes the release of the medication immediate instead of slow. LVN 3 stated administering crushed metoprolol succinate ER 24-hour tablet could result in adverse reactions for Resident 74 such as stomach irritation and uncontrolled blood pressure. LVN 3 stated that LVN 3 failed to follow standard of practice and facility policy and procedures (P&P) for the administration of slow-release medications. During an interview on 6/4/2026 at 10:56 a.m., with the Director of Nursing (DON), the DON stated as a standard of practice nurses should not crush slow-release medications to prevent altering the delivery time of the medication. The DON stated that slow-release medications, such as ER tablets, should not be crushed. The DON stated doing so will make the medication immediate release and cause adverse effects. The DON stated LVN 3 failed not to crush metoprolol succinate ER 24-hour tablet that day (6/3/2026) during morning medication administration, increasing the risk of medication adverse effects, such as stomach irritation and inadequate blood pressure control for Resident 74. During a review of the facility's P&P titled Medication Crushing Guidelines, last reviewed 4/3/2026, the P&P indicated: The solid dosage forms of medications should not be crushed or chewed for a variety of reasons. The nurse administering the medication should check to see that there are no contraindication to crushing the medications in question. The rationale for not crushing some medications includes: D. Timed release tablets are designed to release medication over sustained period, usually 8 to 24 hours. These formulations are utilized to reduce stomach irritation in some cases and to achieve prolonged medication action in other cases. In either case these tablets should not be crushed. Some specific types of timed-release tablets include the following: 1) slow release core. During a review of the facility's provided reference guide, titled DO NOT CRUSH LIST, last reviewed 4/3/2026, the guide indicated: metoprolol succinate tablet is slow-release.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries (PI/PU, injuries to the skin and underlying tissue resulting from prolonged pressure)ˆfor two of four residents (Resident 66 and 82)ˆby failing toˆensure:ˆ ˆ 1.ˆResident 66's bothˆheelsˆwereˆfloatedˆ(a technique of offloading [any method used to reduce or remove] that involves completely suspending or elevating a body part off a bed or support surface)ˆon pillows. 2. Resident 82's low air loss mattress (LALMˆ-ˆdesigned to distribute a patient's body weight over a broad surface area and help prevent skin breakdown)ˆwas set to the resident's weight perˆphysician`s order. These failures placed the residents at risk of discomfort, development of new pressure ulcers and delayed wound healing. Findings:ˆ ˆ 1.ˆDuring a review of Residentˆ66's admission Record, the admission Record indicated the facility admitted Residentˆ66ˆonˆ5/13/2026 withˆdiagnoses that included type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing),ˆAlzheimer's Diseaseˆ(a disease characterized by a progressive decline in mental abilities)ˆand aphasiaˆ(a disorder that makes it difficult to speak).ˆ ˆ During a review of Resident 66's History and Physical (H&P) dated 5/15/2026, the H&Pˆindicatedˆ Resident 66 did not have the capacity toˆunderstand and make decisions.ˆ ˆ Duringˆaˆreview of Residentˆ66's Minimum Data Set (MDS, a resident assessment tool), datedˆ5/9/2026, the MDS indicated Residentˆ66ˆwasˆusuallyˆunderstood by others and wasˆusuallyˆable to understand others andˆneeded supervision/touch assistanceˆ(helperˆprovides verbal cues and or touch assistance)ˆfromˆfacility staff for toileting, bathing,ˆand personal hygiene.ˆThe MDS furtherˆindicatedˆResidentˆ66ˆhadˆtwoˆPU/PI.ˆ ˆ During aˆreview of Residentˆ66's At Risk for Development of PI Care Plan (CP)ˆinitiatedˆon 1/31/26, the CPˆindicatedˆtoˆoff load/float heels while in bed with pillows.ˆ ˆ During a concurrent observation and interview onˆ6/1/2026 at 9:03 a.m. withˆRegistered Nurse 1ˆ(RNˆ1) in Residentˆ66's room, Residentˆ66ˆwas lying in his bed, with hisˆfeetˆflat on bed.ˆRN 1ˆstatedˆResident 66 has PU on both of hisˆheels,ˆand they must be floated on pillows to preventˆfurther injury and promote healing.ˆRN 1 looked around andˆstatedˆthereˆwereˆnot extra pillows to floatˆResident 66ˆheels and she willˆgo getˆsome.ˆRN 1ˆstatedˆit is a collaborative effort to prevent and heal PUˆand any staff member thatˆseesˆResident 66 without his heels floated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should^take a moment to adjust and re-elevate his heels.^^ ^ During a concurrent observation and interview on 6/3/2026 at^1:33^p.m. with the^Licensed Vocational^Nurse (LVN^5) in Resident 66's room, Resident 66^was lying in bed with both feet flat and not elevated.^LVN 5^stated^the pillows should not be on the^nightstand^but under Residents 66's lower legs to elevate his heels^and prevent further skin breakdown.^ ^ During an interview on^6/4/2026 at 1:37 p.m. with the Director of Nursing (DON), the DON stated Resident^66^has wounds on both of his heels^and they must be offloaded on pillows while in bed to^redistribute weight and allow for his heels to continue to heal. The DON^stated^licensed nurses and CNAs must ensure the pillows are readily available in the room and^in use.^^ ^ During a review of the facility's^Policy and Procedure, (P&P)^titled Pressure^Ulcers/Skin Breakdown – Clinical Protocol last reviewed^4/23/2026, the P&P^indicated^the provider will order pertinent wound treatments, including pressure redistribution surfaces.^^ 2. During a review of Resident^82's admission Record, the admission Record^indicated the facility originally admitted the resident on^8/05/2021 and readmitted on [DATE]^with diagnoses^including^quadriplegia (a type of paralysis that impairs or causes a total loss of motor and sensory function in all four limbs [both arms and legs] and the torso and epilepsy (abnormal electrical brain activity). During a review of Resident 82's MDS dated [DATE], the MDS indicated the resident had severely impaired cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and senses. The MDS indicated that Resident 82 was totally dependent on staff for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During an observation on 06/01/2026 at10:24 a.m., observed Resident 82 in his room, lying in bed and sleeping on a LALM bed. The LALM air pump was set to 355 pounds (lbs.) while a sticker attached to the air pump indicated the resident's weight was 155 lbs. During a concurrent observation and interview on 6/01/2026 at 10:33 a.m. with Licensed Vocational Nurse 1 (LVN 1) in the hallway outside Resident 82`s room, LVN 1 stated that the LALM can prevent skin breakdown and can speed up the healing of wounds. LVN 1 stated that the LALM setting can be adjusted based on the weight or the resident's comfort. LVN 1 then went inside Resident 82`s room and confirmed that the LALM setting was at 355 lbs. During a concurrent interview and record review on 6/01/2026 at 10:45 a.m. with LVN 1, Resident 82`s electronic chart was reviewed. LVN 1 reviewed Resident 82`s electronic record and confirmed that Resident 82`s current weight is 155 lbs. LVN 1 stated that 355 lbs. is too high and is not a comfortable setting for a 155-pound resident. LVN 1 stated the LALM would too firm (355 lbs.) and would no longer be therapeutic and instead it can cause skin breakdown which could result to a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure injury. LVN 1 stated that a resident with a pressure injury has the potential to develop infection and if a resident has an existing wound, it can further delay wound healing. During aˆreview of theˆfacility`s policy and procedure (PP) titled Support Surface Guidelines, last reviewed onˆ4/23/2026, the policyˆindicatedˆthat Support surfaces are used for pressure redistribution, shear reduction, and in some cases temperature/moisture control for the resident at risk of pressure injury. ˆDuring aˆreview of theˆfacility`s policy and procedure titled Care Plan Comprehensive (CPC), last reviewed onˆ4/23/2026, the CPC indicated that Care plan interventions are designed after careful consideration of the relationship between the resident`s problems and their causes. During aˆreview of theˆfacility provided User Manual (UM)-Oasis Alternating Pressure with Low Air Loss Mattress,, the UM indicated in the operating instruction on page 7, that the facility will determine the patient`s weight and set the control knob to that weight setting on the control unit. ˆ

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to ensure the environment was free from accidents and hazards by failing to ensure the floor mat did not have the over-bed table on top of the floor mat for one of four sampled residents (Resident 29) investigated under accidents care area. This failure placed Resident 29 at risk for injury should a fall occur. Findings: During a review of Resident 29's admission Record, the admission Record indicated the facility initially admitted Resident 18 on 5/11/2025 and readmitted on [DATE] with diagnoses that included type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) difficulty in walking and muscle weakness, During a review of Resident 29's History and Physical (H&P) dated 5/27/2026, the H&P indicated Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 6/29/2025, the MDS indicated Resident 29 required partial assistance (where helper does less than half the effort) on facility staff for activities such as toileting, bathing, lower body dressing, putting on or taking off shoes and personal hygiene. During a concurrent observation and interview on 6/1/2026 at 9:05 a.m. in Resident 29's room with Certified Nursing Assistant 4 (CNA 4), observed the over-bed table was directly on top of the floor mat on the right side of the bed. Resident 29 was lying in bed on her side, facing the right and in the direct path of the over-bed table if she were to fall out of bed. CNA 4 stated nothing should be on top of the floor mat because Resident 29 could trip over it or fall and hit her head. During a concurrent observation and interview on 6/1/2026 at 2:45 p.m. in Resident 29's room with Certified Nursing Assistant 4 (CNA 4), observed the over-bed table was directly on top of the floor mat on the right side of the bed again. CNA 4 stated she must have forgotten to move the over-bed table after providing care. During an interview on 6/4/2026 at 1:46 p.m. with the Director of Nursing (DON), the DON stated staff must make sure the residents are safe and nothing should be on top of any floor mat because the purpose of the floor mats are to provide a cushion if a resident were to fall off the bed. The DON stated the over-bed table is especially dangerous because it has metal legs and a metal bar attached to the leg that house the wheels. During a review of the facility's policy and procedure (P&P) titled, Accidents/Incidents last reviewed on 4/23/2026, the P&P indicated the facility must provide a safe and secure environment for staff and residents.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that a resident who was receiving dialysis (clinical purification of blood as a substitute for the normal function of the kidney) treatment received services consistent with professional standards of practice by failing to ensure the post dialysis assessment was completed for one of two sampled residents (Resident 29) investigated under the dialysis care area. This deficient practice placed the resident at risk for missed monitoring and delayed identification of complications associated with renal disease and dialysis, including hypertension, fluid overload, shortness of breath, and the potential need for hospitalization.Findings: During a review of Residentˆ29's admission Record, the admission Record indicated the facilityˆinitiallyˆadmitted Resident 18 onˆ5/11/2025ˆand readmitted on [DATE]ˆwith diagnoses that includedˆtypeˆIIˆdiabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing)ˆand dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) During a review of Residentˆ29's History and Physical (H&P) datedˆ5/27/2026, the H&PˆindicatedˆResidentˆ29ˆdid not have the capacity to understand and make decisions.ˆˆˆ During a review of Residentˆ29's Minimum Data Set (MDS, aˆresidentˆassessment tool), dated 6/29/2025, the MDS indicated Residentˆ29 required partial assistance (where helper does less than half the effort)ˆon facility staff for activities such asˆtoileting,ˆbathing, lower bodyˆdressing, putting on or taking off shoes and personal hygiene and required dialysis. ˆˆ During a record review of Resident 13's Pre and Post Dialysis binder on the following dates, the Pre and Post Dialysis binder indicated the following: 2/27/2026 - pre/post dialysis weights left blank. 3/02/2026 - no post dialysis weight 3/06/2026 - pre/post dialysis weights left blank; no post blood pressure. 3/11/2026 - pre/post dialysis weights left blank. 3/18/2026 - pre/post dialysis weights left blank. 4/07/2026 - no post dialysis weight 4/10/2026 - the post dialysis form was completely blank. 4/13/2026 - no post dialysis weight 4/24/2026 - no post dialysis weight During a concurrent interview and record review on 6/1/2026 at 10:49 a.m., with Licensed Vocational Nurse (LVN) 5, LVN 5 reviewed Resident 29's Pre and Post Dialysis Assessment forms and verified the post dialysis assessment part of the form was not completed on 2/27/26, 3/02/2026, 3/06/2026, 3/11/2026, 3/18/2026, 4/07/2026, 4/10/2026, 4/13/2026 and 4/24/2026. LVN 5 stated the charge nurses are responsible for completion of the form upon the resident's arrival back to the facility to ensure there were no signs of complication such as abnormal vital signs (a measurement of basic functions of the body), bleeding, and/or altered mental status. LVN 5 stated if the facility forgot to fill out the pre/post weight, it is the receiving charge nurse's duty to call the dialysis facility to get the missing information. During an interview on 6/4/2026 at 1:36 p.m. the Director of Nursing (DON), the DON stated the licensed nurses are responsible to complete the post dialysis assessment portion of the Pre and Post Assessment form upon resident's return to the facility and should include the vital signs, weights and signs or symptoms of bleeding to ensure that the resident is stable and there are no signs of complications. During a review of the facility's policy and procedure titled, Dialysis Care, last reviewed 4/23/2026 indicated the licensed nurses shall document the date and time of the resident's return from the treatment, vital signs, and an assessment of the response to treatment. Nurses shall review the dialysis center's paperwork and communicate recommendations, lab results, etc. to the attending physician when necessary.

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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. Based on interview and record review, the facility failed to maintain complete and accurate clinical records for one of five sampled residents (Resident 48) reviewed for unnecessary medications by failing to document Resident 48's bloodˆglucose (BG-the main sugar found in the bloodstream) levels and the insulin (medication that lowers the blood sugar)ˆadministered to Resident 48, in the MedicationˆAdministrationˆRecord (MAR) on 5/28/2026 and 5/30/2026. This failure placed the resident at risk for not receiving appropriate care and treatment due to incomplete information in the medical record. Findings: Duringˆaˆreview of Residentˆ48'sˆadmission Record, the admission Recordˆindicated the facility originally admitted Resident 48ˆon 4/29/2025ˆand re-admitted ˆtheˆresident on 5/16/2024, with diagnoses including acute respiratory failure (condition where the lungs cannot adequately exchange oxygen and carbon dioxide, leading to low oxygen), type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing),and sepsis (a life-threatening blood infection). ˆ During a review of Residentˆ48's Minimum Data Set (MDS-a resident assessment tool), datedˆ2/27/2026,ˆthe MDS indicated Residentˆ48's cognition (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) was severely impaired. The MDS indicated that Resident 48 was receiving medications classified as high risk for hypoglycemia (low blood sugar), including insulin. During a review of Resident 48's Order Summary Report dated 6/1/2026, the Order Summary report indicated an order, dated 5/16/2026, for Insulin Lispro (a fast acting insulin used to help people with diabetes control their blood sugar after meals) 100 u/ml (units/milliliter - units of measurement), inject as per sliding scale. During a review of Resident 48's MAR datedˆ5/1/106 to 5/31/2026,ˆthe MARˆindicatedˆthe areas designated for documenting the resident's blood glucose level and the insulin administered were left blank on 5/28/2026 and 5/30/2026 at 6 p.m. During a concurrent interview and record review on 6/03/2026 at 4:49 p.m. with the Director of Nursing (DON), Resident 48's MAR dated 5/1/2026ˆtoˆ5/31/2026 was reviewed. The DON stated that the areas designated for documenting the blood sugar results and the units of insulin administered were left blank on 5/28/2026 and 5/30/2026 for the 6 p.m. dose. The DON stated the MAR was incomplete and that licensed nurses should have documented the units of insulin administered and the blood sugar levels on the designated area immediately after checking the blood sugar and administering the insulin. The DON stated staff are required to document these findings in the MAR, and failure to do so compromises resident safety and increases the risk for hyperglycemia (high blood sugar). During an interview on 6/04/2026 at 1:54 p.m. with Licensed Vocational Nurse (LVN 2), LVN 2 stated he was the assigned nurse to Resident 48 on 5/28/2026, and that he forgot to document the blood sugar result and the units of insulin administered to Resident 48 on the MAR on 5/28/2026 at 6 p.m. LVN 2 stated he should have documented the blood sugar level and the insulin administered to Resident 48 immediately after checking the resident's blood sugar and after administering the insulin to the resident. The LVN 2 acknowledged that failure to document this information could result in Resident 48 experiencing high blood sugar levels that may not be reported to the physician. During aˆreview of facility's P&P titled, Charting and Documentation, reviewed onˆ4/23/2026,ˆthe P&P indicatedˆdocumentation in medical record will be objective, complete and accurate. During aˆreview of facility's P&P titled, Medication Administration, revised onˆ4/23/2026,ˆthe P&P indicatedˆdocumentation of MedicationˆAdministration,ˆthe individual administering theˆmedication initials the resident's MAR on theˆappropriate lineˆafter giving each medication and before administering the next ones. As required or indicated for medication, the individual administering the medication records in the resident's medical records: ˆ ˆThe date and time the medication was administeredˆˆ ˆ ˆThe dosageˆˆ ˆ ˆThe route of administrationˆˆ ˆ ˆThe injection site (if applicable)ˆˆ ˆ ˆAny complaints or symptoms for which the drug was administeredˆˆ ˆ ˆAny results (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	achieved and the time such results were observed^^ ^ ^The signature and title of the person administering the drug.^

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure Certified Nursing Assistant 3 (CNA 3) and the Physician Assistant (PA) wore appropriate personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while performing high contact activities (tasks involving prolonged or close physical interaction) to one of three sampled residents (Resident 47) placed on enhanced barrier precautions (EBP- infection control interventions to prevent the spread disease). This failure had the potential to result in staff spreading multidrug-resistant organisms (MDRO - bacteria or germs that have developed resistance to multiple antibiotics, making infections hard to treat) to other residents. Findings: During a reviewˆResident 47's admission Record, the admission Recordˆindicated the facility admitted Resident 47 on 10/14/2025 with diagnoses including but not limited to pressure ulcer of sacral region (a wound on the tissue over the sacrum - the triangular bone at the base of the spine), pyogenic arthritis (a painful and dangerous infection of joint tissues and fluid), and severe protein-calorie malnutrition (a life-threatening condition caused by lack of protein and calories in the diet). During a review of Resident 47's History and Physical (H&P), dated 10/15/2025, the H&Pˆindicatedˆ Resident 47 does not have the capacity to understand and make decisions.ˆ During a review of Resident 47's Physician Orders, dated 3/20/2026, the Physician Orders indicated an order for EBP to place Resident 47 on EBP for high risk for infection or transmission related to MDRO, history of Proteus mirabilis (a type of bacteria that commonly lives in the intestines but can cause infections when it spreads to other parts of the body) in the urine every shift. During a review of Resident 47's Care Plan (CP), revised 3/20/2026, the CP indicated an intervention to use gown and gloves when performing high-contact activities such as dressing, bathing and showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use of a device, and wound care. During a concurrent observation and interview on 6/1/2026 11:01 a.m. with Certified Nursing Assistant (CNA) 3ˆin Resident 47's room, CNA 3ˆchanged and put away Resident 47's dirty linen without using PPE. CNA 3 stated PPE was not worn because only the bed sheet was changed. CNA 3 stated she received PPE training about two weeks ago and was aware that PPE should be worn when providing incontinence care and changing linens. During an observation on 6/2/2026 at 10:48 a.m. in Resident 47's room, the Physician Assistant (PA) was performing an ear exam on Resident 47 without wearing PPE. During an interview on 6/2/2026 at 10:55 a.m. with the PA, the PA stated PPE was not worn while performing an ear exam on Resident 47. because EBP sign was overlooked before entering Resident 47's room. The PA stated PPE should be worn when providing care to a resident with an EBP order to reduce the risk of spreading infection to other residents. During a concurrent interview and record review on 6/4/2026 at 11:10 a.m. with the Infection Preventionist Nurse (IPN), CNA 3's Personal Protective Equipment Competency Skill Check (PPE Check) form was reviewed. The PPE Check form did not indicate the date training was completed, signature and date of evaluator, and competency skills check marks. During a concurrent interview and record review on 6/4/2026 at 11:51 a.m. with the Director of Staff Development (DSD), the Annual CNA Competency form for CNA 3, dated 9/25/2025 was reviewed. The Competency form did not indicate CNA 3 received EBP or PPE training. During a review of the facility's policy and procedure (P&P) titled, Enhanced Standard/Barrier Precautions, revised 2/21/2025, the P&P indicated the facility: a. Implements EBP for the prevention of MDRO transmission for high-contact resident care activities including dressing, bathing, transferring, providing hygiene, changing linens, changing briefs/toileting, device care, and wound care. b. Provide EBP staff training upon hire and at least annually. c. Communicate to staff which residents require EBP prior to providing high contact care activities.

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	06/04/2026

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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record review, the facility failed to ensure two of three sampled staff, (Certified Nursing Assistant [CNA] 3 and Licensed Vocational Nurse [LVN] 3), received enhanced barrier precautions (EBP - infection control interventions to prevent the spread disease) competency training. This failure had the potential to result in the spread of infectious organisms (germs that may cause disease or harm) to residents when staff are not trained, assessed, and monitored to ensure infection control and prevention standards of practice are followed. Findings: During a concurrent interview and record review on 6/4/2026 at 11:10 a.m. with the Infection Preventionist Nurse (IPN), the IPN was unable to provide documentation that CNA 3 and LVN 3 received EBP training. During a concurrent interview and record review on 6/4/2026 at 11:51 a.m. with the Director of Staff Development (DSD), the Annual CNA Competency form for CNA 3 dated 9/25/2025, and Initial/Annual License Nurse Competency form for LVN 3 were reviewed. The competency forms did not indicate CNA 3 and LVN 3 received EBP training. During a concurrent interview and review on 6/4/2026 at 12:45 p.m. with the IPN, the facility's policy and procedure (P&P) titled, Competency of Nursing Staff, last reviewed on 4/23/2026, was reviewed. The P&P indicated competency skills includes but is not limited to basic nursing skills and infection control with competency evaluations conducted upon hire, annually, and as necessary based on assessment. The IPN stated she did not have records indicating that CNA 3 and LVN 3 had completed their annual competency assessments and evaluations. During an interview on 6/4/2026 at 12:56 p.m. with the Director of Nursing (DON), the DON stated annual competency training should be provided to ensure staff are providing care based on standards of care. The DON stated she was unable to locate documentation of CNA 3's and LVN 3's annual competency assessments and EBP training During an interview on 6/4/2026 at 1:35 p.m. with the Director of Nursing (DON), the DON stated the facility should educate newly hired staff and staff who did not pass competency skills assessment until they are able to perform duties in accordance with accepted standards of care. The DON stated the IPN provides infection control and prevention skills checks for all nursing staff. The DON stated the facility failed to follow its P&P by not ensuring staff received training and evaluation in proper infection prevention and control practices including proper use of PPE and hand hygiene; and place residents at risk for infection transmission. During a review of the facility's policy and procedure (P&P) titled, Enhanced Standard/Barrier Precautions, last reviewed on 4/23/2026, the P&P indicated facility staff will receive EBP training upon hire and at least annually and are expected to comply with the designated precautions. During a review of the Infection Preventionist (IP) job description, dated 7/1/2025, the job description indicated the IP plan, develop, implement, evaluate and oversee the infection prevention and control program, and ensure the facility's compliance with current federal, state, and local regulations. During a review of the Director of Staff Development (DSD) job description, dated 1/3/2022, the job description indicated the duties and responsibilities of the DSD include development, evaluation, and control of the quality of in-service educational programs in accordance with the policies and procedures.