STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555748	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Berkley East Healthcare Center	2021 Arizona Ave Santa Monica, CA 90404

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its policy and procedures (P&P) titled Self-Administration for Medications revised 1/2026 for three of three residents sampled (Residents 24, 48 and 91) by failing to ensure there was documented assessment for self-administration before:1. Allowing Resident 91 to self-administer 2 (two) medications.2. Leaving unidentified medications at Resident 48's bedside.3. Leaving a medicine cup with thick, smooth and rich white substance on Resident 24's nightstand. This deficient practice had the potential for:1. Incorrect medication of administration that may or may not result in medication error, and / or negative outcome to resident's health condition.2. Unauthorized access/ingesting to the medications by confused and wandering residents(s) resulting in anaphylaxis, choking, unnecessary hospitalization, and/or death.Findings: A. During an observation on 3/05/2026 at 9:34 AM outside of Resident 91's room with the licensed vocational nurse (LVN 1), LVN 1 was preparing 17 medications for Resident 91. Two of 17 medications were as followed: Symbicort (a combination inhaler of budesonide/formoterol, used for the long-term maintenance treatment of asthma and chronic obstructive pulmonary disease or COPD, a type of inflammatory lung disease causing obstructed airflow, to improve breathing and reduce flare=ups) 80/4.5 milligrams (mg, unit to measure mass) Spiriva HandiHaler (tiotropium bromide powder in capsule, used to relax airway muscles to improve breathing. LVN 1 placed 1 cap in the inhaler and primed the inhaler. During the medication administration observation on 3/05/2026 at 9:55 AM, Resident 91 requested to self-administer Symbicort and Spiriva, and Resident 91 proceeded to pick up the Symbicort inhaler from a tray on the table in front of the resident. Resident 91 shook inhaler and inhaled 1 puff, waited about 10 seconds, then took another puff by mouth. Next, Resident 91 placed the Symbicort inhaler in the tray and picked up Spiriva and self-administered 1 puff. During an interview on 3/05/2026 at 9:57 AM, LVN 1 stated Resident 91 was alerted and oriented, and the resident would sometime prefer to self-administer certain medications. During an interview on 3/05/2026 at 2:38 PM, LVN 1 stated she could not find Resident 91's self-administration of medication assessment. During a concurrent review of Resident 91's care plans, LVN 1 stated she didn't see a care plan to monitor proper self-administration of medication. Also, LVN 1 could not find a physician order for self-administration. During an interview on 3/05/2026 at 2:54 PM, with the facility Quality Assurance nurse (QA) and the (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistant director of nursing (ADON), ADON stated there should be a physician order stating resident could self-administer and a nurse completed a self-administration medication assessment form, before the resident can self-administer medications. QA confirmed resident 91 did not have a physician order. During a review of the facility policy and procedures, Self-Administration of Medications (dated 1/2026), the policy indicated . the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. The staff and practitioner will perform a more specific skill assessment. will document their findings and residents who are able to self-administer medications. B. A review of Resident 48's admission record indicated Resident 48 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that include osteomyelitis of Vertebra (infection in the spine.), Type 2 diabetes (high blood glucose (sugar) levels, which are caused by the body's inability to properly use insulin), end stage renal disease (ESRD- permanent, irreversible kidney failure), metabolic encephalopathy (neurologic disorders characterized by an alteration in mental status) and dependence on renal dialysis (life sustaining medical treatment to remove waste and excess fluid from the blood). A review of Resident 48's Minimum Data Set (MDS - a resident assessment tool) dated 2/6/2026 indicated the resident 48's cognition (The mental ability to make decision of daily living) was moderately impaired. The MDS indicated Resident 48's required supervision/touching assistance for eating and oral hygiene, partial/moderate assistance with upper body dressing, and substantial/maximal assistance with toileting/hygiene, shower/bathe, lower body dressing and putting on/taking off footwear. During a facility tour on 3/2/2026 at 8:51 AM, Resident 48's bedside drawer was observed to have 2 (two) medicine cups with unknown tablets in each cup. During an interview on 3/2/2026 at 8:59 am Assistant Director of Nursing (ADON) stated Resident 48 had temporarily left the facility for dialysis. ADON also stated she did not know the purpose and nature of medication tablets that were in the medication cups left at bedside. ADON further stated Residents are required to take their medications as soon as they are administered and it is not safe to leave medications unattended at bedside because a confused Resident could wander into t Resident 48's room, consume the medications which could resulting in anaphylaxis, choking, unnecessary hospitalization, poor overall outcomes and/or death. During an interview on 3/6/2026, at 10:50 am, the Director of Nursing (DON) stated Residents are only allowed for have Meds at bedside if they have been assessed to be cognitive and physically demonstrated they can safely able to do so and have a physician approval, DON stated medication at bedside should be in a locked container. The DON further stated medications should not be left at bedside, because of the risk of duplicity that can lead to an overdose, a confused wandering Resident may consume the medications which could lead to an adverse reactions, unnecessary hospitalization and possible poor outcomes, A review of the facility's policy and procedures (P&P) titled Self-Administration of Medication dated 01/2026 indicated, .Residents have the right to self-administer medications if the interdisciplinary team (IDT- a group of health care professionals with various areas of expertise who work together toward the goals of the Resident), has determined that it is clinically appropriate and safe for the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident to do so. As part of their overall evaluation, the staff and practitioner will assess each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the Resident. Self-administered medications are stored in a safe and secure place, which is not accessible by other Residents. C. A review of Resident 24's admission Record indicated the facility admitted Resident 24 on 2/9/2026 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), atrial fibrillation (Afib - heart condition causing an irregular, often rapid heart rate), and diabetes (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 24's MDS dated [DATE], indicated Resident 24 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 24 required setup/clean up to partial/moderate assistance from staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. During a concurrent observation and interview on 3/3/2026, at 10:03 A.M., with Resident 24, in Resident 24's room, a thick, smooth and rich white substance was in a medicine cup on Resident 24's nightstand. Resident 24 stated that the white cream in the medicine cup was cream for his legs that the nurse gave to him. During a concurrent observation and interview on 3/3/2026, at 11:21 A.M., with LVN 1, in Resident 24's room, a white thick, smooth and rich substance was on Resident 24's nightstand. LVN 1 stated that the white substance in the medicine cup was resident 24's cream, LVN 1 stated she could not tell the surveyor what the cream was, she would have to ask the treatment nurse to say what it exactly was. LVN 1 stated that the cream should definitely not be on the residents' nightstand because a confused resident can walk and ingest the medications. LVN 1 stated potential adverse outcome if another resident ingests the medication is that they may get adverse reactions to the medications. During a concurrent observation and interview on 3/3/2026, at 11:28 A.M., with LVN 2 in the hallway with LVN 2 holding the medicine cup with the cream in her hands. LVN 2 stated that the cream in the medicine cup was Amlactin (cream that is a moisturizer and a chemical exfoliant to soften dry, rough or bumpy skin) which should not be left be left at the resident's bedside unattended. LVN 2 stated that if cream is left at the bedside unattended, a confused resident can eat it and put the medication where is should not be maybe in their eyes which can cause irritation and an allergic reaction if they are allergic to it. LVN 2 stated the cream should not be left at the bedside and application should be done by the treatment nurse. During a concurrent interview and record review on 3/5/2026, at 9:145 A.M., with the DON, Resident 24 electronic medical record was reviewed. the DON stated the facility process for residents to have their medication at the bedside is that if the residents is cognitively able to self-administer their own medication, a medication self-medication assessment is completed and if the resident's assessment states they are able to safely self-administer their medication, their medication is to be locked in the nurses cart or locked at the residents bedside. The DON stated that resident 24 did not have a medication self-administration assessment completed prior to medication being found at the resident bedside, facility completed one on 3/3/2026 after surveyor requested for the assessment. The DON stated that resident's medication should not be left unattended at the bedside because if there is a resident that is not cognitively aware, they may take that medication and depending on the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication, it can affect the patient's health adversely and possibly lead to hospitalization. A review of the Facility P&P titled Self-Administration for Medications revised 1/2026, indicated that: Policy Statement Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. A review of the Facility P&P titled Medication Administration revised 1/2026, indicated that: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. A review of the Facility P&P titled Hazardous Areas, Devices and Equipment revised 1/2026, indicated that: Identification of Hazards 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to: . g. Access to toxic chemicals; Assessment and Analysis of Hazards.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide Resident 127 with a communication tool that was accessible in the resident's language, easily readable, and within reach according to the resident's Care Plan, dated 2/28/2026, the Care Plan on communication deficit related to hearing impairments, and facility's policy and procedures (P&P) titled Communication-Cognitive Deficit, reviewed 1/2026. This failure had the potential to result in Resident 127's inability to communicate with staff his needs, preferences, and requests. Findings: During a review of Resident 127's admission Record indicated the resident was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses of, but not limited to, generalized muscle weakness, hydrocephalus, diabetes mellitus type 2 (a group of diseases that result in too much sugar in the blood), major depressive disorder, hypertension (HTN-high blood pressure), prostate cancer, failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and dementia (a progressive state of decline in mental abilities). During a review of Resident 127's Quarterly Minimum Data Set (MDS- a resident assessment tool) dated 2/26/2026, indicated the resident had severe cognitive impairment with significant limitations in memory, orientation, and attention. The MDS indicated Resident 127 needs substantial/maximal assistance with putting on and off footwear, dressing, toilet use, bathing. The MDS indicated Resident 127's had clear speech, makes himself understood, was able to understand others and preferred language is Farsi. During a review of Resident 127's Physician Orders, dated 3/5/2026, the Physician Orders, did not indicate an order for a communication board/tool. During a review of Resident 127's admission Record, dated 3/5/2026, indicated that Resident 127's primary language is Persian. During a review of Resident 127's Care Plan, dated 2/28/2026, the Care Plan indicated due to Resident 127's communication deficit related to hearing impairments, the facility to provide the resident with a communication board with gestures, actions, and pictures. During an observation on 3/2/2026, at 9:45 a.m., during the initial tour of the facility, Resident 127 was observed in his room, sitting in a wheelchair, awake, alert but unable to respond to verbal commands with the call light behind him on the bedside dresser. Multiple attempts was made to ask about the call light, however, Resident 127 was unable to verbally communicate or respond. During an observation on 3/2/2026 at 9:50 a.m., a stack of papers containing both clear and unclear images labeled Persian was seen on the resident's bedside drawer next to the call light. Additionally, a single-page document with unclear images and no translation was found pinned on a board across Resident 127's bed below the television. During an interview on 3/2/2026, at 10 a.m. with the CNA (Certified Nurse Assistant) 1, CNA 1 stated, he uses one worded commands because Resident 127 does not ask for assistance, so we just keep an eye on him. During an interview on 3/2/2026 at 10:25 a.m. with the Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 127 does not have any communication boards to assist with communication with staff and visitors. During an interview on 3/6/2026 at 10:49 a.m. with the Director of Nursing (DON), the DON stated that the facility provides communication folders for residents that have difficulty communicating with staff. The DON stated the folders/tools include photos with translations, making them simple to use for those who have trouble communicating. The DON stated each communication folder/tool should be kept on the resident's wheelchair or bedside table, so it is always easily accessible. During a review of the facility's policy and procedures titled, Communication-Cognitive Deficit, reviewed 1/2026, indicated, Residents shall receive communication support consistent with their primary language and communication abilities.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the Minimum Data Set (MDS - resident assessment tool) was accurately documented according to their policy and procedure (P&P) titled Certifying Accuracy of the Resident Assessment reviewed 1/2026 for two of two sampled residents (Residents 66 and 127). This deficient practice resulted in Resident 66 and Resident 127's medical records being inaccurate and missing vital information of services being rendered to the resident.Findings: A. During a review of Resident 127's admission Record indicated the resident was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses of, but not limited to, generalized muscle weakness, hydrocephalus, diabetes mellitus type 2 (a group of diseases that result in too much sugar in the blood), major depressive disorder, hypertension (HTN-high blood pressure), prostate cancer, failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and dementia (a progressive state of decline in mental abilities). During a review of Resident 127's MDS, dated [DATE], Section B indicated Resident 127 had the ability to make herself understood and understand others; Section C, Brief Interview for Mental Status (BIMS) is 4 out of 15 which indicated Resident 127's cognition level is severely impaired. During a review of Resident 1's Care Plan, dated 2/28/2026, indicated the resident has impaired cognitive function or impaired thought processes related to dementia and a communication deficit related to his hearing impairments. The interventions consisted of using a communication board, giving access to pencil and paper for writing needs, and enhancing spoken words with gestures, actions, pictures, or other non-verbal methods. During an interview on 3/5/2026 at 12:40 p.m. with the Minimal Data Set Director (MDSD), the MDSD stated all of Section B of the MDS must be reassessed because it does not reflect the resident's current health status. During a concurrent interview and record review on 3/5/2026 at 10:49 a.m. with the Director of Nursing (DON), MDS dated [DATE] was reviewed. Section B of the MDS indicated, Resident 127 had the ability to make herself understood and understand others. The DON stated, the MDS is not correct because Resident 127 does not always understand and staff cannot always understand Resident 127. The DON stated, a reassessment must be done to correct the problem or Resident 127 will risk having an incorrect individualized plan of care. During a review of the facility's policy and procedure (P&P) titled, Certifying Accuracy of the Resident Assessment, reviewed 1/2026, indicated All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. During a review of the facility's policy and procedures (P&P) titled Resident Assessment Instrument dated 10/1/2023, indicated, The MDS Nurse / Coordinator / UM Nurse will be responsible to update assessment schedule manually or electronically (in EHR) for reference of members of the IDT whenever applicable. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. A review of Resident 66's admission Record indicated the facility admitted Resident 66 on 1/26/2026 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), emphysema (a chronic, progressive lung disease—part of COPD where the alveoli [tiny air sacs]in the lungs are damaged and lose their elasticity, causing them to break and form larger, less efficient pockets), and hypothyroidism (a condition where the butterfly-shaped gland in the neck does not produce enough thyroid hormones). A review of Resident 66's MDS dated [DATE], indicated Resident 66 is cognitively impaired (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 66 required partial/moderate assistance to dependency on staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. The MDS indicated in section O, under check all that apply, the hospice section was blank and below it none of the above was checked off. A review of Resident 66's physician's order dated 2/6/2026 indicated that patient admitted to hospice (specialized, compassionate care for people with terminal illnesses (typically with less than 6 months to live) . diagnosis COPD . During a concurrent interview and record review, on 3/5/2026, at 9:20 A.M., with MDS Director (MDSD), Resident 66's electronic chart was reviewed. The MDSD stated that a significant change of condition (SCOC) in the MDS id done when a resident has had either a decline or improvement in two areas that affect the resident as a whole. MDSD stated that hospice requires a SCOC in the MDS. The MDSD stated that resident 66 was on hospice however, the MDS indicated no/blank and should have indicated yes/mark with an X. The MDSD stated that it is important that the MDS indicates accurate information that will determine the proper care that the resident needs to be provided. The MDSD stated that if the MDS is inaccurate, the resident may not get the proper care that they require. During an interview on 3/5/2026, at 10:21 A.M., with the DON, the DON stated that the MDS assessments is utilized to derive a plan of care and/or to tailor the appropriate plan of care for the resident according to the assessment performed. The DON stated that an inaccurate MDS assessment may affect the plan of care for the resident and the residents care may not be individualized for them. A review of facility's P&P titled Certifying Accuracy of the Resident Assessment, reviewed 1/2026 indicated that: Policy Statement All personnel who complete any portion of the Resident Assessment (MDS) must sign and certify the accuracy of that portion of the assessment. A review of the CMS RAI Version 3.0 dated 10/2025, indicated, . For these sections, the person signing the attestation must review the information to assure accuracy and sign for those portions on the date the review was conducted. For sections requiring resident interviews, the person signing the attestation for completion of that section should interview the resident to ensure the accuracy of information and sign on the date (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this verification occurred.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the interdisciplinary team (IDT team, a collaborative group of professionals-including doctors, nurses, social workers, and therapists-who work together to create and implement a unified, patient-centered care plan) assess and evaluate the ability to self-administration medications for one (1) of 3 residents sampled for medication administration observations (Resident 91).This deficient practice had the potential to cause incorrect or unsafe medication administration that may or may not cause a negative outcome to resident's health condition. Findings: During a review of Resident 91's admission record, Resident 91 was admitted on [DATE] with diagnoses included but not limited to: chronic obstructive pulmonary disease (or COPD, a type of inflammatory lung disease causing obstructed airflow, to improve breathing and reduce flare-ups), disorder of muscle, and abnormalities of gait and mobility. During an observation on 3/05/2026 at 9:34 AM outside of Resident 91's room with the licensed vocational nurse (LVN 1), LVN 1 was preparing 17 medications for Resident 91. Two of 17 medications were as followed:Symbicort (a combination inhaler of budesonide/formoterol, used for the long-term maintenance treatment of asthma and COPD) 80/4.5 milligrams (mg, unit to measure mass)Spiriva HandiHaler (tiotropium bromide powder in capsule, used to relax airway muscles to improve breathing. LVN 1 placed 1 cap in the inhaler and primed the inhaler. During the medication administration observation on 3/05/2026 at 9:55 AM, Resident 91 requested to self-administer Symbicort and Spiriva, and Resident 91 proceeded to pick up the Symbicort inhaler from a tray on the table in front of the resident. Resident 91 shook inhaler and inhaled 1 puff, waited about 10 seconds, then took another puff by mouth. Next, Resident 91 placed the Symbicort inhaler in the tray and picked up Spiriva and self-administered 1 puff. During an interview on 3/05/2026 at 2:54 PM, with the facility Quality Assurance nurse (QA) and the assistant director of nursing (ADON), and a concurrent review of Resident 91's interdisciplinary team (IDT team, a collaborative group of professionals, including doctors, nurses, social workers, and therapists, who work together to create and implement a unified, patient-centered care plan) notes (dated 9/19/2025 and 12/23/2025), QA stated IDT notes did not document discussion of self-administration of medications. During a review of the facility policy and procedures, Self-Administration of Medications (dated 1/2026), the policy indicated Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. The staff and practitioner will periodically (for example, during quarterly MDS reviews) reevaluate a resident's ability to continue to self-administer medications.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, and interview, the facility failed to observe and maintain their infection control measures according to their Policy and Procedure (P&P), titled Infection Prevention & Control Program Policy, reviewed 10/2026, for one of one sampled residents (Resident 24) when Resident 24's nebulizer (a small electric machine that turns liquid medication into fine mist) mask was on Resident 24's night stand not stored in a plastic bag according to their P&P titled Administering Medication through a small Volume (Handheld) Nebulizer, reviewed 1/2026. This deficient practice had the potential to cause infection and/or hospitalization for Resident 24. Findings: A review of Resident 24's admission Record indicated the facility admitted Resident 24 on 2/9/2026 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), atrial fibrillation (Afib - heart condition causing an irregular, often rapid heart rate), and diabetes (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 24's Minimum Data Set (MDS - resident assessment tool) dated 2/13/2026, indicated Resident 24 is cognitively intact (when a person has no trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated Resident 24 required setup/clean up to partial/moderate assistance from staff with Activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) care. During a concurrent observation and interview on 3/3/2026, at 10:03 A.M., with Resident 24, in Resident 24's room, a nebulizer machine was on Resident 24's nightstand, with the nebulizer mask was placed on top of the nebulizer machine and not in a bag. Resident 24 stated that he had COPD and uses the nebulizer machine as needed (PRN) and that the last time he used the nebulizer machine was last night. During a concurrent observation and interview on 3/3/2026, at 11:21 A.M., with Licensed Vocations Nurse 1 (LVN1), in Resident 24's room, a nebulizer machine was on Resident 24's nightstand, with the nebulizer mask was placed on top of the nebulizer machine and not in a bag. LVN 1 stated that resident 24's nebulizer mask had been used and left on top of the nebulizer machine. LVN 1 stated that resident 24's nebulizer mask should be cleaned and placed in a bag to keep it clean, prevent contamination of the nebulizer mask which may cause the resident to have an infection. LVN 1 stated she would get a new mask and place it in a bag to make sure that resident 24 has a clean mask. During an interview with on 3/5/2026, at 9:45 A.M., with the Director of Nursing (DON), the DON stated that the nebulizer mask when not in use needs to be stored in a plastic to keep it clean and non-contaminated. The DON stated that if the nebulizer machine is not stored in a plastic bag, it may place residents at risk for bacterial contamination when not store properly and possibly lead to hospitalization. A review of the Facility P&P titled Infection Prevention and Control Program, reviewed 1/2026, indicated that:Policy statement:An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. A review of the Facility P&P titled Administering Medication through a small Volume (Handheld) Nebulizer, reviewed 1/2026, indicated that .27. Rinse and disinfect the nebulizer equipment according to facility protocol, or:a. Wash pieces with warm, soapy water;b. Rinse with hot water;c. Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes);d. Rinse all pieces with sterile water (NOT tap, bottled, or distilled); ande. Allow to air dry on a paper towel.29. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it.

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	555748	A. Building B. Wing	03/06/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility's staff and practitioner failed to ensure medications were not left at the bed side unattended for two out of two sampled residents (Residents 24 and 48) according to the facility's policy and procedures (P&P) titled Medication Storage In The Facility with a reviewed date of 1/2026. This deficient practice had the potential for confused residents and residents with wandering behavior to gain access and ingest the medications which could result in anaphylaxis reaction (undesirable), choking, unnecessary hospitalization and/or death.Findings: 1. A review of Resident 48's admission record indicated Resident 48 was originally admitted to the facility on [DATE] and re-admitted on [DATE], with diagnoses that include osteomyelitis of Vertebra (infection in the spine.), Type 2 diabetes (high blood glucose (sugar) levels, which are caused by the body's inability to properly use insulin), end stage renal disease (ESRD- permanent, irreversible kidney failure), metabolic encephalopathy (neurologic disorders characterized by an alteration in mental status) and dependence on renal dialysis (life sustaining medical treatment to remove waste and excess fluid from the blood). A review of Resident 48's Minimum Data Set (MDS - a resident assessment tool) dated 2/6/2026 indicated the resident 48's cognition (The mental ability to make decision of daily living) was moderately impaired. The MDS indicated Resident 48's required supervision/touching assistance with activities of daily (ADL - eating and oral hygiene, partial/moderate assistance with upper body dressing, and substantial/maximal assistance with toileting/hygiene, shower/bathe, lower body dressing and putting on/taking off footwear). During a facility tour on 3/2/2026 at 8:51 AM, Resident 48's bedside drawer was observed to have 2 (two) medicine cups with unknown tablets in each cup. During an interview on 3/2/2026 at 8:59 am Assistant Director of Nursing (ADON) stated Resident 48 had temporarily left the facility for dialysis. ADON also stated she did not know the purpose and nature of medication tablets that were in the medication cups left at bedside. ADON further stated Residents are required to take their medications as soon as they are administered and it is not safe to leave medications unattended at bedside because a confused Resident could wander into t Resident 48's room, consume the medications which could resulting in anaphylaxis, choking, unnecessary hospitalization, poor overall outcomes and/or death. During an interview on 3/6/2026, at 10:50 am, the Director of Nursing (DON) stated Residents are only allowed for have Meds at bedside if they have been assessed to be cognitive and physically demonstrated they can safely able to do so and have a physician approval. The DON stated medication at bedside should be in a locked container. The DON further stated medications should not be left at bedside, because of the risk of duplicity that can lead to an overdose, a confused wandering Resident may consume the medications which could lead to an adverse reactions, unnecessary hospitalization and possible poor outcomes, A review of the facility's policy and procedures (P&P) titled Medication Storage In The Facility with a reviewed date of 1/2026, indicated, Policy: Medications and biologicals are stored safely, securely, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. 2. A review of Resident 24's admission Record indicated the facility admitted Resident 24 on 2/9/2026 with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), atrial fibrillation (Afib - heart condition causing an irregular, often rapid heart rate), and diabetes (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). A review of Resident 24's MDS dated [DATE], indicated Resident 24 is cognitively intact. The MDS indicated Resident 24 required setup/clean up to partial/moderate assistance from staff with ADLs (activities such as bathing, dressing and toileting a person performs daily) care. During a concurrent observation and interview on 3/3/2026, at 10:03 A.M., with Resident 24, in Resident 24's room, a thick, smooth and rich white substance was in a medicine cup on Resident 24's nightstand. Resident 24 stated that the white cream in the medicine cup was cream for his legs that the nurse gave to him. During a concurrent observation and interview on 3/3/2026, at 11:21 A.M., with LVN 1, in Resident 24's room, a white thick, smooth and rich substance was on Resident 24's nightstand. LVN 1 stated that the white substance in the medicine cup was resident 24's cream, LVN 1 stated she could not tell the surveyor what the cream was, she would have to ask the treatment nurse to say what it exactly was. LVN 1 stated that the cream should definitely not be on the residents' nightstand because a confused resident can walk and ingest the medications. LVN 1 stated potential adverse outcome if another resident ingests the medication is that they may get adverse reactions to the medications. During a concurrent observation and interview on 3/3/2026, at 11:28 A.M., with LVN 2 in the hallway with LVN 2 holding the medicine cup with the cream in her hands. LVN 2 stated that the cream in the medicine cup was Amlactin (cream that is a moisturizer and a chemical exfoliant to soften dry, rough or bumpy skin) which should not be left be left at the resident's bedside unattended. LVN 2 stated that if cream is left at the bedside unattended, a confused resident can eat it and put the medication where is should not be maybe in their eyes which can cause irritation and an allergic reaction if they are allergic to it. LVN 2 stated the cream should not be left at the bedside and application should be done by the treatment nurse. During a concurrent interview and record review on 3/5/2026, at 9:145 A.M., with the DON, Resident 24 electronic medical record was reviewed. the DON stated the facility process for residents to have their medication at the bedside is that if the residents is cognitively able to self-administer their own medication, a medication self-medication assessment is completed and if the resident's assessment states they are able to safely self-administer their medication, their medication is to be locked in the nurses cart or locked at the residents bedside. The DON stated that resident 24 did not have a medication self-administration assessment completed prior to medication being found at the resident bedside, facility completed one on 3/3/2026 after surveyor requested for the assessment. The DON stated that resident's medication should not be left unattended at the bedside because if there is a resident that is not cognitively aware, they may take that medication and depending on the medication, it can affect the patient's health adversely and possibly lead to hospitalization. A review of the Facility P&P titled Self-Administration for Medications revised 1/2026, indicated that: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the resident's: a. Ability to read and understand medication labels; b. Comprehension of the purpose and proper dosage and administration time for his or her medications; c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and d. Ability to recognize risks and major adverse consequences of his or her medications. 8. Self-administered medications must be stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer will be stored on a central medication cart or in the medication room. Nursing will transfer the unopened medication to the resident when the resident requests them. A review of the Facility P&P titled Medication Administration revised 1/2026, indicated that: Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Facility P&P titled Hazardous Areas, Devices and Equipment revised 1/2026, indicated that: Identification of Hazards 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to: . g. Access to toxic chemicals; Assessment and Analysis of Hazards.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one of two sampled residents (Resident 127) according to the facility's policy and procedures (P&P) titled, Call Lights: Accessibility and Timely Response, revised on 10/2025. This deficient practice had the potential to result in staff delay in meeting Resident 127's needs for hydration, toileting, and activities of daily living. Findings: During a review of Resident 127's admission Record indicated the resident was originally admitted to the facility on [DATE], and was readmitted on [DATE], with diagnoses of, but not limited to, generalized muscle weakness, hydrocephalus, diabetes mellitus type 2 (a group of diseases that result in too much sugar in the blood), major depressive disorder, hypertension (HTN-high blood pressure), prostate cancer, failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain), and dementia (a progressive state of decline in mental abilities). During a review of Resident 127's Quarterly Minimum Data Set (MDS- a resident assessment tool) dated 2/26/ 2026, indicated the resident had severe cognitive impairment with significant limitations in memory, orientation, and attention. The MDS indicated that Resident 127 needs substantial/maximal assistance with putting on and off footwear, dressing, toilet use, bathing. The MDS indicated Resident 127's has clear speech, makes himself understood, is able to understand others and his preferred language is Farsi. During a review of Resident 127's admission Record dated 3/5/2026, indicated that Resident 127's primary language is Persian. During a review of Resident 127's Health and Physical (H&P), dated 3/2/2026, the H&P indicated patient occasionally said yes/no to some questions but was mostly non-verbal. During an observation on 3/2/2026, at 9:45 a.m., during the initial tour of the facility, Resident 127 was observed in his room, sitting in his wheelchair, awake, alert but unable to respond to verbal commands with the call light behind him on the bedside dresser. Multiple attempts were mad to ask Resident 127 about his call light, however, Resident 127 was unable to verbally communicate or respond. During an interview on 3/2/2026, at 10 a.m. with the CNA (Certified Nurse Assistant) 1, CNA 1 stated, he uses one-word commands because Resident 127 does not ask for assistance, so we just keep an eye on him. CNA 1 stated Resident 127, does not know how to use the call light, so I just put it behind him, so it's out in the open. If the call lights fall or break, they are expensive as hell. During an interview on 3/2/2026 at 11 a.m. with the LVN (Licensed Vocational Nurse) 1, LVN 1 stated it should always be placed in front of Resident 127 and within easy reach, but it was not positioned in front of Resident 127. LVN 1 stated the call light should always be in front of the Resident 127 if he needs to call for help. During a concurrent observation and interview on 3/5/2026 at 12:10 p.m. with the Social Services Assistant (SSA) in the dining room, Resident 127 was observed nodding yes to two out of five questions when spoken to in Farsi. Resident 127 was able to verbalize that he preferred to speak in Farsi. During an interview on 3/6/2026 at 10:49 a.m. with the Director of Nursing (DON), the DON stated that call lights are meant for residents to request staff help and should always be in their dominant hand for easy access. The DON stated if a call light is out of reach or not visible, residents could fall or miss needed assistance. The DON stated that for Resident 127, the call light was behind him, making it inaccessible. During a review of the facility's policy and procedures (P&P) titled, Call Lights: Accessibility and Timely Response, revised on 10/2025, indicated, Staff should facilitate call light placement within reach of resident and secure it as needed.