STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555846	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joyce Eisenberg Keefer Medical Center D/P Snf	7150 Tampa Avenue 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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify residents of the existence and the location of the results of the most recent standard survey (means the Statement of Deficiencies Form CMS-2567) for ten (Resident 189, Resident 30, Resident 51, Resident 59, Resident 62, Resident 65, Resident 83, Resident 203, Resident 219, and Resident 236) of 11 sampled residents in the resident council. This deficient practice had the potential for residents and their representative to not know how the facility is performing regarding resident care. Findings: a. During a review of Resident 189's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included hypertension (high blood pressure). During a review of Resident 189's Minimum Data Set (MDS, a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 189 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. b. During a review of Resident 30's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE], with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 was cognitively intact with skills required for daily decision making. c. During a review of Resident 51's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included generalized muscle weakness During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 was cognitively intact with skills required for daily decision making. d. During a review of Resident 59's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypotension (low blood pressure). During a review of Resident 59's MDS, dated [DATE], the MDS indicated Resident 59 was cognitively intact with skills required for daily decision making. e. During a review of Resident 62's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included osteoarthritis. During a review of Resident 62's MDS, dated [DATE], the MDS indicated Resident 62 was cognitively intact with skills required for daily decision making. f. During a review of Resident 65's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness. During a review of Resident 65's MDS, dated [DATE], the MDS indicated Resident 65 was cognitively intact with skills required for daily decision making. g. During a review of Resident 83's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypertension. During a review of Resident 83's MDS, dated [DATE], the MDS indicated Resident 83 was cognitively intact with skills required for daily decision making. h. During a review of Resident 203's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness. During a review of Resident 203's MDS, dated [DATE], the MDS indicated Resident 203 was cognitively intact with skills required for daily decision making. i. During a review of Resident 219's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on (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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 219's MDS, dated [DATE], the MDS indicated Resident 219 was cognitively intact with skills required for daily decision making. j. During a review of Resident 236's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included muscle weakness. During a review of Resident 236's MDS, dated [DATE], the MDS indicated Resident 236 was cognitively intact with skills required for daily decision making. During a review of the facility's Resident Council Meeting Minutes, the minutes indicated no information that residents were made aware of the survey results on the following dates: 11/26/2025, 12/17/2025, and 1/29/2026. During an observation and interview with the residents during the resident council task meeting interview on 3/09/2026 at 2:36 p.m., 10 of the 11 residents (Resident 189, Resident 30, Resident 51, Resident 59, Resident 62, Resident 65, Resident 83, Resident 203, Resident 219, and Resident 236) stated they were not aware of survey results for them to review or where the survey results were located. The 10 residents stated no one told them about survey results. During an observation on 3/11/2026 at 7:45 a.m., observed survey results binder attached to the wall in an area near the first-floor nursing station which indicated the last recertification survey was 12/20/2024. During an interview with the Activities Director (AD) on 3/11/2026 at 9:04 a.m., she stated all survey results were posted near the dining room entrance on every floor and is within reach of the residents. The AD stated she has not told residents in the resident council meetings about the existence of the survey results or where they were located. The AD stated it is important for the residents to know about past survey results and where they are located. The AD stated many of the residents are very involved and active in what occurs in the facility and knowing about the survey results should be part of their involvement. During an observation with the AD on 3/11/2026 at 9:10 a.m., the AD showed the survey team the location of the fourth-floor survey results. Observed the survey binder in a holder near the dining area entrance containing the previous recertification survey results, dated 12/20/2024. During an observation on 3/11/2026 at 9:10 a.m., observed the survey binder in a holder near the third-floor dining area entrance containing the previous recertification survey results, dated 12/20/2024. During an interview with the Director of Nursing (DON) on 3/12/2026 at 8:30 a.m., the DON stated residents should be made aware of the previous year's survey results and their location. The DON stated the residents have the right to review the survey results to remain informed. During a review of facility's policy and procedures (P&P) titled, Administrative Manual, reviewed on 4/16/2025, the P&P indicated, Most recent licensing visit report (survey)/complaint investigations, and the related follow-up plan of correction visit, in areas of the facility that are prominent and accessible to the public have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review.

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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 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. Based on interview and record review, the facility failed to ensure adequate monitoring of resident's orthostatic blood pressure (taking blood pressure measurements when lying, sitting, and standing to detect for significant drop in blood pressure during each position change) when taking a prescribed antipsychotic medication for one out of five residents (Resident 81) reviewed under unnecessary medications. This failure had the potential to result in Resident 81 receiving inappropriate dosage of an antipsychotic medication and experiencing symptoms of orthostatic hypotension (a significant drop in blood pressure with position change), which could lead to serious complications such as fainting and falls. Findings: During a review of Resident 81's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 81 on 6/29/2023, with diagnoses including: vascular dementia (loss of cognitive functioning-thinking, remembering, and reasoning), psychosis (a mental health symptom involving a loss of contact with reality) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). ˆ During review of Resident 81's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 12/17/2025, the MDS indicated Resident 81 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and is dependent (helper does all the effort) for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).ˆ ˆ During a review of Resident 81's Physician Order Report, the Physician Order Report indicated Resident 81 has a physician order for Seroquel (an antipsychotic medication used to treat mental health conditions) 12.5 milligrams (mg-unit of measurement) every day at bedtime, dated 8/8/2025.ˆThe physician's order also indicated to monitor for side effects of Seroquel use: which includes headache, somnolence (state of being sleepy or drowsy), weight gain, orthostatic hypotension, anticholinergic effects (confusion, constipation, dry mouth, blurry vision, urinary retention), dizziness, hypotension (low blood pressure), and tardive dyskinesia (uncontrollable, repetitive, and abnormal body movements). Orthostatic blood pressure was ordered to be taken every Saturday evening. During a concurrent interview and record review with Registered Nurse Supervisor (RN) 3 on 3/12/2026 at 12:10 pm, Resident 81's medical record was reviewed. Resident 81's medical record did not indicate documented evidence of orthostatic blood pressure monitoring being performed from 8/1/2025 through 3/12/2026. RN 3 stated the certified nursing assistant (CNA) or licensed vocational nurse (LVN) should document why the orthostatic blood pressure could not be taken and communicate that to the physician. RN 3 stated there was no documentation on Resident 81's medical record why orthostatic blood pressures were not taken and confirmed there was no communication with the physician regarding the inability to monitor blood pressures. During an interview on 3/12/2026 at 2:00 pm with the Director of Nursing (DON), the DON stated the inability to take the orthostatic blood pressure for psychotropic monitoring should be documented in the medical record and communicated to the physician because if the nurses do not document the orthostatic blood pressures, the physician will not know if the resident is having side effects from Seroquel and cannot make adjustments to the medication or interventions if needed. ˆ During a review of facility's policy and procedures (P&P) titled, Orthostatic Blood Pressure, reviewed on 4/2025, the P&P indicated, Orthostatic vital signs shall be taken and recorded when ordered by the physician.ˆ During a review of the facility's P&P titled, Medication (Psychotherapeutic Drug Management), reviewed 4/2025, the P&P indicated the facility will monitor all psychotherapeutic medications for effectiveness and side effects like postural hypotension.

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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 facilityˆfailed toˆdevelop and implement a comprehensive person-centered care plan (a document outlining a detailed approach to care customized to an individual resident's need) for: 1.One of two sampled residents (Resident 1) with a moisture associated damage (MASD) investigated during review of pressure ulcer/pressure injury (PU/PI - injury to the skin and underlying tissue resulting from prolonged pressure on the skin). 2. One of two sampled residents (Resident 180) whose care plan did not include all interventions agreed upon by the interdisciplinary team (IDT - a collaborative group of health care team members from different specialties who work together to address all aspects of resident's well-being) investigated for falls. Theseˆdeficient practicesˆhad the potential to negatively affect the provision of care and service provided for the residents. 3. One ofˆtwoˆsampled residents (Resident 4) to address the resident's preferred activity of listening to music investigated under activities. This deficient practiceˆhad potential forˆResident 4ˆtoˆnot receiveˆhis preferred activity which canˆaffect theˆresident`s sense of self- worth and well-being.ˆˆˆ 4. Oneˆof five sampled residents (Resident 72)ˆon Transmission Based Precautions (TBP -ˆextra infection control measures used in healthcare settings, beyond standard precautions, for patients known or suspected to be infected with highlyˆinfectious pathogens [virus, bacteria, fungus]) investigated during the infection control task. This deficient practiceˆhad potential forˆResidentˆ72ˆtoˆnot receiveˆthe necessary care and servicesˆneededˆto prevent the spread of infection.ˆ 5. One of five sampled residents (Resident 81) when orthostatic blood pressures (taking blood pressure measurements when lying, sitting, and standing to detect for a significant drop in blood pressure during each position change) could not be done to monitor for side effects ofˆSeroquelˆ(prescription medicationˆto treat mood disorder or used as an antipsychotic). This failure had the potential toˆhave the resident receive improper medication usage, unmonitored side effects, and incorrect dosage ofˆSeroquel.ˆ Findings: 1. During a review of Resident 1's Face Sheet (FS - the front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted Resident 1 to the facility on [DATE]. The FS indicated Resident 1 was admitted with diagnosis that included bacterial pneumonia (serious lung infection caused by bacteria), chronic respiratory failure (long-term condition where the lungs cannot sufficiently transfer oxygen into the blood) and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). During a review of the History and Physical (H&P) report completed on 1/13/2026, the H&P indicated Resident 1 is able to make her own needs known and has the capacity to make her own medical decisions. During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 1 is able to make self-understood and able to understand others. The MDS indicated Resident 1 was dependent (helper does all of the effort) with toileting hygiene and substantial/maximal assistance (helper does more than half the effort) for personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 1 was dependent for chair/bed-to-chair transfer, tub/shower transfer, and substantial/maximal assist for roll left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed). During an interview on 3/11/2026 at 1:55 p.m. with Registered Nurse (RN) 6, RN 6 stated Resident 1 was initially assessed on 3/2/2026 by RN 4 on 3/2/2026 to have a pressure injury (PI – injury (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the skin and underlying tissue resulting from prolonged pressure on the skin) on right buttocks measuring 1.5cm x 1.4 cm x 0.2 cm. RN 6 stated that on the following day on 3/3/2026, she had re-assessed the right buttocks wound and determined it was a MASD, not a PI. RN 6 stated she did not make changes to Resident 1's care plan after she re-assessed the wound to ensure the care plan for Resident 1 is relevant and tailored to resident 1's specific care needs. RN 6 stated that the care plan required revision and that a dedicated care plan addressing MASD should have been established. During an interview on 3/12/2026 at 10:05 a.m. with Director of Nursing (DON), the DON stated that a care plan serves as the guide on how to care for the residents. The DON stated because Resident 1's wound was determined to be different than what was care planned, a care plan for MASD should have been created. The DON stated it is important that care plans are current and updated to reflect the plan of care for the resident's actual condition. 2. During a review of Resident 1's FS, the FS indicated the facility originally admitted Resident 180 on 01/14/2021 and was re-admitted on [DATE]. The FS indicated Resident 180 was admitted with diagnosis that included atherosclerotic heart disease (a condition where fat, cholesterol, and calcium found in the blood builds up inside the heart's arteries, causing them to narrow and harden), unspecified psychosis (a condition when a person loses clear signs of losing touch with reality but does not fully meet criteria for defined mental illness) and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). During review of the H&P report completed on 1/15/2021, the H&P indicated Resident 180 has impaired decision-making capacity. During a review of Resident 180's MDS, dated [DATE], the MDS indicated Resident 180's ability to express ideas and wants was limited to making concrete requests and responds adequately to simple, direct communication only for ability to understand others. The MDS indicated Resident 180 required substantial/maximum assistance with eating and dependent with all other activities of daily living. The MDS indicated that Resident 180 was dependent on all aspects of functional mobility. During a concurrent observation and interview on 3/11/2026 at 8:50 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 180's room, observed Resident 180 had a unique mattress. The mattress was hollowed with cushions built in on the sides raising from the mattress. CNA 3 stated Resident 180's mattress is used to prevent resident from falls. CNA 3 could not state what the mattress is called. During an interview on 3/11/2026 at 9:24 a.m. with RN 6, RN 6 stated Resident 180 has a concave mattress. RN 6 stated that when the interdisciplinary team (IDT) identifies post- fall that sliding out of bed is the reason for the fall, providing concave mattress is part of the intervention implemented to prevent future falls. RN 6 stated a physician order is not required for the concave mattress and that the risk for fall care plan would indicate when a resident has a concave mattress. During a concurrent interview and record review on 3/11/2026 at 9:44 a.m. with Minimum Data Set Coordinator (MDSC) 3, Resident 180's care plan dated 3/11/2026 was reviewed. The care plan did not list the concave mattress as a fall prevention intervention. MDSC 3 stated it should have been in the care plan. MDSC 3 stated the MDSC would have known to add it if he had been present when the intervention was discussed during health care team meeting. MDSC 3 stated he does not know why the use of concave mattress was not in Resident 180's care plan as a as a fall prevention intervention. MDSC 3 stated he may not have been present during the meeting when it had been (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discussed for Resident 180 to have concave mattress and it was not communicated to him or another MDSC did not enter it when should have. During a follow-up interview with RN 6 on 3/11/2026 at 11:44 a.m., RN 6 stated she had reviewed Resident 1's records and found the concave mattress was an intervention agreed upon by IDT after Resident 130's fall on 2/5/2021. During a review of Resident 180's safety Events – Post Accident Assessment and Interventions dated 2/5/2021, the form indicated based on root cause analysis list interventions added or direct to care plan/s added includes concave mattress .IDT agreed with above interventions. During an interview with the Director of Nursing (DON) on 3/12/2026 at 10:05 a.m., the DON stated agreed upon IDT recommendations should be added to resident's care plan timely. The DON stated that not having the concave mattress in Resident 180's care plan had the potential of having the mattress removed not knowing it is part of Resident 180's plan of care. The DON stated the care plan is the guide for how the health care team takes care of the resident. Every resident should have an individualized comprehensive care plan that is current. During a review of the facility's P&P titled, Fall Reduction/Prevention Program last reviewed 4/16/2025, the P&P indicated, All residents/patients on admission, quarterly, post fall and significant change in condition, will be assessed for fall risk and when such risk is identified , the resident/patient will be noted as a fall risk with appropriate interventions placed in the medical record.Following a resident fall: The IDT, which may include the DON/designee, RN Unit Manager, Social Services, MDS Coordinator, CNA, Charge Nurse and Activities, will review the medical record, pharmacy recommendations and all other factors that may contribute to the resident fall, and create an appropriate, individualized care plan to address each resident's needs and goals with interventions specific to the root cause of the fall. During a review of the facility's P&P titled, Care Plan - Comprehensive last reviewed 4/16/2025, the P&P indicated, An individualized comprehensive care plan that includes measurable objectives and timetables to meet resident/patient's medical, nursing, mental, and psychological needs is developed for each resident/patient. Procedure Each resident/patient's comprehensive care plan has been designed to: a. Incorporate identified problem areas b. Incorporate risk factors associated with identified problems; c. Build on residents/patients' strengths; d. Reflect treatment goals and objectives in measurable outcomes e. Identify the professional services that are responsible for each element of care Care plans are revised as changes in the resident/patient's condition dictate.Care plan goals and objectives are defined as the desired outcome for a specific resident/patient problem. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Goals and objectives are reviewed and/or revised: a. When there has been a significant change in resident/patient condition b. When the desired outcome has not been achieved. Using the Care Plan Changes in the resident/patient's condition must be reported to the MDS Assessment Coordinator so that a review of the resident/patient's assessment and care plan can be made. Documentation must be consistent with the resident/patient's care plan 3. During a review of Residentˆ4's FS, the FS indicated the resident was originally admitted to the facility on [DATE] and readmitted on [DATE]ˆwith diagnoses that includedˆdementia (a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and seizures (a sudden burst of electrical activity in the brain).ˆˆ ˆ During a review of Residentˆ4's MDS, dated [DATE], the MDS indicated the resident`s cognitive skills for daily decision making was severely impaired andˆtotally 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). The MDS alsoˆindicatedˆthat the resident's activity preferences include listening to music.ˆ ˆ During an observation onˆ03/09/2026ˆatˆ1:20ˆp.m.,ˆobservedˆResident 4 awake in bed and had difficulty expressing herself when spoken to. The television was observed to be off, and there was no music paying in the room. ˆ During a concurrent interview and record reviewˆon 03/11/2026 at 8:15 a.m., with Licensed Vocational Nurse 6 (LVN 6) reviewedˆResident 4`sˆCare Plan for Activitiesˆdated 02/07/2026 and MDS dated [DATE]. ˆ LVN 6 stated that the MDS under Section F (identifies resident's preferences about daily routines and activities) indicated music isˆespecially importantˆto Resident 4.ˆ LVN 6 stated that theˆcare plan should be resident specific based on the assessment and the resident's needs. LVN 6 stated that a care plan serves as communication tool among the care team to ensure everybody is aware about the resident's specificˆactivity needs. LVN 6 stated thatˆthe care plan should have addressed the resident's preferred activity of listening to music to ensure the resident's activity needs are met. ˆ During a review of the facility`s P&Pˆtitledˆ Resident/Patient/Person Centered Care, last reviewed onˆ4/16/2025, the P&P indicated thatˆPerson-Centered Care is provided or care planned to meet theˆresident comprehensive individual needs as established by the Physician, IDT, and resident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and/or responsible party, which provides^the highest reasonable and feasible psychosocial well-being and overall health of the resident.^ 4. During a^review of Resident^72's FS, the FS^indicated^the facility admitted the resident on^2/17/2026^with diagnoses including^unspecified^severe sepsis^(a life-threatening blood infection)^and^Parkinson's^disease^(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements).^^ ^^ During a review of Resident^72's^H&P dated^12/10/2025, the H&P^indicated^Resident^72^speaks in full sentences, was able to make her^own needs known and able to make^simple^medical decisions.^^^^ ^^ During a^review of Resident^72's MDS, the MDS indicated^Resident^72^usually makes herself understood and usually understands others. The MDS further^indicated^Resident^72^needs^substantial^assistance^with^upper body and lower^dressing, personal hygiene^and putting on and taking off shoes.^^ ^ During a review of the facility provided matrix (A^list^of residents^combined with a checklist that^identifies^who has specific care needs^such as TBP) on 3/9/2026, the matrix indicated Resident 72 was identified as being placed on TBP.^^ ^ During a review of Resident 72's Clostridioides difficile (C.diff^-a bacteria^that causes severe diarrhea and intestinal inflammation) test results dated 3/6/2026, the test results^indicated^Resident 72^ tested positive for C.diff^toxins (harmful substance that C. diff produces) and required the resident to be placed on contact isolation^ (infection control measures to prevent the spread of germs passed by direct or indirect touch). ^ During^review^of Resident 72's care plans on 3/9/2026 at 9:05 a.m., there was no care plan addressing TBP. ^^ During a concurrent interview^record review^on^3/12/2026^at^2:28^p.m.,^with the DON, the DON^stated^care plans are^basically a^manual of specific care for each individual resident. The DON^stated^licensed staff^must create an individualized care plan^when there is a change of condition such as^C. Diff^requiring TBP for Resident 72.^The DON^stated^the care plan should have been completed on 3/6/2026 when the resident tested positive for C. diff ^so staff would know how to care for the resident and prevent the spread of infection.^^ (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^^ During aˆreview of the facility's P&Pˆtitled,ˆResident/Patient/Person Centered Care, last reviewed onˆ4/16/2025, the P&P indicated thatˆPerson-Centered Care is provided or care planned to meet theˆresident comprehensive individual needs as established by the Physician, IDT and resident and/or responsible party, which providesˆthe highest reasonable and feasible psychosocial well-being and overall health of the resident.^^ 5. During a review of Resident 81's FS the FS indicated the facility originally admitted Resident 81 on 6/29/2023, with diagnoses including: vascular dementia (loss of cognitive functioning-thinking, remembering, and reasoning), psychosis (a mental health symptom involving a loss of contact with reality) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy).ˆ During review of Residentˆ81's MDS, ˆdatedˆ12/17/2025, the MDS indicated Residentˆ81ˆhas severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making andˆis dependentˆfor activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).^^ ˆ Duringˆaˆconcurrentˆinterviewˆand record reviewˆon 3/12/2026 at 12:10ˆpm with RN 3,ˆResident 81's care plan titled, Behavioral symptoms related to Seroquel, dated 8/11/2025 was reviewed.ˆThe care planˆindicatedˆto monitor side effects of Seroquel including orthostatic hypotension (a significant drop in blood pressure when measuring orthostatic blood pressures).ˆRN 3 statedˆorthostatic blood pressures can be done forˆResident 81. Residentˆ81 mostly liesˆin bed butˆcanˆbe placed in a reclining wheelchairˆtoˆobtain orthostatic bloodˆpressure.ˆRN 3ˆstatedˆthere is no documentationˆindicatingˆwhy orthostatic blood pressure could not be done andˆthere is no care plan toˆindicateˆhow toˆproperly measureˆResident 81'sˆorthostaticˆblood pressure. Resident 81's further stated orthostatic blood pressureˆhasˆonly been measured once since the Care plan wasˆinitiatedˆon 8/11/2025.ˆ ˆ During an interview on 3/12/2026 at 2:00 pm with the DON,ˆthe DONˆstatedˆan individualized care plan for measuring orthostatic blood pressure should have been created and implemented for Resident 81.ˆThe DONˆstatedˆrepeated inability to measureˆorthostatic blood pressure should have been reported so that the care plan could be individualized and give proper interventions toˆmonitorˆfor orthostatic hypotension.ˆ ˆ During a review of the facility's P&P titled, Care Plans – Comprehensive, reviewed 4/2025, the P&P indicated, when goals and objectives are not achieved, the resident/patient's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will beˆmodifiedˆaccordingly. The P&P alsoˆindicatesˆthat it is the responsibility of the Certified Nursing Assistants (CNA) to reportˆto the nurse supervisor when care plan goals andˆobjectivesˆhave not been achieved.ˆ (continued on next page)

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	555846	A. Building B. Wing	03/12/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ ^

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement the facility's infection control policy when: 1. An incorrect sign was placed on the door of one of one resident (Resident 72) on transmission-based precautions (TBP - extra infection control measures used in healthcare settings, beyond standard precautions, for patients known or suspected to be infected with highly infectious pathogens [virus, bacteria, fungus] investigated under the infection control task. This deficient practice had the potential to increase the risk of spreading infection to other residents.ˆ 2 Licensed Vocational Nurse 3 (LVN 3)ˆwas observed leaving a resident's room during a medication pass observation while still wearing an isolation gown for one (Residentˆ40) ofˆ13ˆresidents whoˆwereˆon enhanced barrier precautionsˆ(EBP-a method of using personal protective equipment [PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments] to reduce the spread of pathogens between residents in skilled nursing facilities).ˆˆ This deficient practice had the potential to increase the risk of spreading infection to other residents.ˆ Findings:ˆ ˆ 1. During aˆreview of Residentˆ72's Face Sheet, the Face Sheetˆindicated the facility admitted the resident onˆ2/17/2026ˆwith diagnoses including unspecifiedˆsevere sepsisˆ(a life-threatening blood infection)ˆand Parkinson's diseaseˆ(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements).ˆ ˆ During a review of Residentˆ72'sˆHistory and Physical (H&P) datedˆ12/10/2025, the H&PˆindicatedˆResidentˆ72ˆspeaks in full sentences, was able to make herˆown needs known and able to makeˆsimpleˆmedical decisions.ˆˆˆ ˆ During aˆreview of Residentˆ72's Minimum Data Set (MDS - an assessment and care screening tool) datedˆ2/13/2026, indicated Residentˆ72ˆusually makes herself understood and usually understands others. The MDS furtherˆindicatedˆResidentˆ72 required substantial assistanceˆ(helper does more than half the work)ˆwithˆupper body and lowerˆdressing, personal hygieneˆand putting on and taking off shoes.ˆ During a review of the facility provided matrix (Aˆlist of residents combined with a checklist that identifies who has specific care needs such as TBP) on 3/9/2026, Resident 72 was identified as being placed on TBP. During a review of Resident 72's Clostridioides difficile (C.diff, a bacterium that causes severe diarrhea and intestinal inflammation) test results dated 3/6/2026, the test results indicated Resident 72 was positive for C.diff toxins (harmful substance that C. diff produces) and requires contact isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ˆ During a concurrent observation and interview onˆ3/10/2026ˆatˆ9:42ˆa.m. outside of Residentˆ72's roomˆwith the Infection Preventionist (IP), the IP looked at the contact precautions (infection spread by touching) sign on the door and stated it was in fact the wrong sign. The IP stated C. diff infections require handwashing to remove the C.diff spores (the dormant, inactive, and highly resistant form that can live for months) from the hands and the current contact precaution sign instructed to use alcohol-based hand rub (ABHR - a liquid, gel, or foam antiseptic [chemical substance meant to kill germs] designed to kill the majority of germs on hands without the need for soap and water) and that sign is not enough to prevent the spread of C. diff. ˆ During an interview onˆ3/13/2026ˆatˆ2:28ˆp.m.,ˆwithˆthe Director of Nursing (DON), the DONˆstatedˆlicensed staff are responsible for checking and observing infection control guidelines to keep residents safe. The DON stated that for C. diff infections, the sign must include to wash the hands with soap and water after assisting the resident to ensure all the spores are washed off. ˆ During a review of the facility's policy and procedureˆ(P&P)ˆtitled, Guideline for Isolation Precautions, last reviewedˆ4/16/2025,ˆthe P&Pˆindicated there are three different kinds of transmission (mode in which the germs can infect) and contact is one of the three. The P&P stated contact transmission is when germs are transferred directly from person to person through touch. The P&P further indicated residents with C.diff will be placed on contact and spore precaution indicating the need for handwashing with soap and water. 2. During a review of Residentˆ40's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on [DATE]ˆand re-admitted on [DATE]ˆwith diagnoses that includedˆdysphagia (difficulty swallowing),ˆattention to gastrostomyˆ(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems).ˆ ˆ During a review of Residentˆ40' s MDS, dated [DATE], the MDS indicated Residentˆ40ˆwas severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Residentˆ40ˆwas dependent (helper does all the effort) on staff for eating.ˆThe MDS indicated Resident 40 has a gastrostomy tubeˆ(G-tube,ˆa plastic tube inserted into the stomach to infuse medications for one who has problems swallowing).ˆ ˆ During a review of Residentˆ40's Physician's Orders,ˆdated 12/18/2024,ˆthe physician's ordersˆindicatedˆEPB are toˆbeˆmaintainedˆduring high-contact residentˆcare activities due to G-tube feeding.ˆ ˆ (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a medication pass observation withˆLVN 3ˆonˆ3/11/2026ˆatˆ3:58ˆp.m., observedˆLVN 3ˆtakingˆResident 40'sˆblood pressure inˆisolationˆgown and gloves.ˆLVN 3ˆthenˆremovedˆtheir gloves andˆwalkedˆtowards the medication cart which was placed right outsideˆResidentˆ40's roomˆat theˆdoorway.ˆLVN 3 wasˆstill wearing anˆisolationˆgown.ˆˆWhenˆasked if his isolation gown couldˆpotentiallyˆcome in contact withˆthe medication cart, heˆstatedˆhe was not awareˆthis could be an infection control issue.ˆˆ During an interview with the DON onˆ3/12/2026 at 8:15 a.m.,ˆthe DONˆstatedˆstaff providing care forˆresidents who are on EBP, the practice is to remove the isolation gownˆand glovesˆbefore leaving a resident's room.ˆThe DON statedˆLVN 3ˆshould have removed the gownˆbeforeˆexitingˆResidentˆ40's room. The DONˆstatedˆthis was important toˆprevent the spread of infection.ˆˆ During a review of the facility's policy and procedure titled, Enhanced Barrier Precautions,ˆlast reviewedˆ4/16/2025,ˆthe policy indicated EBP is used in conjunction withˆstandard precautionsˆ(a set of infection control practices that are used to prevent the spread of disease in healthcare settings, such as hand washing)ˆand expand the use of PPE during high-contact resident care activities.ˆThe policy indicated EBPˆareˆto be used forˆresidents withˆindwellingˆmedical devices, such as a G-Tube, even if the resident is not known to be infected or colonized with aˆmultidrug-resistantˆorganism (MDRO,ˆbacteria that are resistant to three or more classes of antimicrobial drugs).ˆThe policyˆindicatedˆthe PPE: gloves and gown, are to beˆused in maintaining EBP.ˆ

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: a. Ensure to provide the name of the medication and its indication (reason for the use of the medication) prior to administration of the medication for one of four (Resident 59) residents observed for medication administration. This deficient practice violated Resident 59's rights to make decisions regarding her medication regimen. b. Obtain informed consent for the use of bed siderails for one of two (Resident 101) residents reviewed for restraints. This deficient practice violated Resident 101's right to be informed of and participate in the resident's treatment. Findings: a. During a review of Resident 59's admission Record (AR), the AR indicated the facility originally admitted the resident on 06/02/2022 and readmitted on [DATE] with diagnoses including chronic respiratory failure (can occur when your blood has too much carbon dioxide or not enough oxygen) and age-related osteoporosis (bones lose their ability to regrow and reform themselves). During a review of Resident 59's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/12/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS indicated that Resident 59 required partial/moderate (helper does less than half the effort) assistance for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During a concurrent observation and interview on 3/11/2026 at 4:43 p.m., with Licensed Vocational Nurse 5 (LVN 5), observed LVN 5 administering midodrine (a medication used to treat low blood pressure) 5 milligrams (mg-unit of measurement), Senokot-S (a medication used to treat constipation [infrequent and difficult bowel movements]) 8.6 mg, Trelegy Ellipta (an inhaler used to treat chronic obstructive pulmonary disease [COPD-an ongoing lung condition caused by damage to the lungs]) 200-62.5-25 micrograms (mcg-unit of measurement), Miralax (medication used to treat constipation) 17 grams (gm-unit of measurement), and Tylenol (a medication used to relive pain) 325 mg orally to Resident 59, followed by administering Systane (a medication used to lubricate [to hydrate, soothe, and protect the surface of the eyes]) to both eyes. Resident 59 was not observed informing Resident 59 of the name of each medication and its indication during administration of the medications. When LVN 5 was asked why she did not inform the resident of the names of the medications and their indication, LVN 5 stated she was not aware that it was required per facility policy. During an interview on 3/12/2026 at 09:08 a.m., with the Director of Nursing (DON), the DON stated that residents have the right to be informed about their care including their medications. The DON stated not providing information about their medication regimen restricts Resident 59 from exercising this right. During a review of the facility`s Administrative Manual, last reviewed on 04/16/2025, the administrative manual indicted that the resident has the right to: Make decisions about his/her medical condition Accept or refuse the proposed treatment. b. During a review of Resident 101's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 11/17/2025 and readmitted on [DATE] with diagnoses including hypertension (high blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 101's MDS dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated that Resident 101 required partial/moderate (helper does less than half the effort) assistance for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During a concurrent interview and record review on 3/12/2026 at 09:08 a.m., with the DON, reviewed Resident 101's Informed Consent for Bed Rail Use, dated 11/19/2026. The DON stated that the consent was not completed as it did not include the signature of Resident 101 or the resident's representative, the reason for the use of side rails, or the licensed nurse's signature indicating that the consent was obtained and verified. The DON stated that the resident's rights were not protected as consent was (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not obtained and no explanation was provided regarding the reason for the use of side rails. During a review of the facility`s policy and procedures (P&P) titled Bed Rails, last reviewed on 04/16/2026, the P&P indicated that if the IDT determines that bed rails are appropriate, they will use the Informed Consent for Bed Rail Use form prior to installation. The information will be presented to the resident, or if applicable, the resident representative, in a manner that is understood and that consent is given voluntarily, free form coercion.

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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. Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a patient to signal his or her need for assistance from a professional staff) was within reach for one of one sampled resident (Resident 72) investigated during a random observation. This deficient practice had the potential to result in Resident 72 not being able to call for facility staff assistance and delay in the provision of necessary care and services which could negatively affect the residents' comfort and well-being. Findings: During a review of Resident 72's Face Sheet, the Face Sheet indicated the facility admitted the resident on 2/17/2026 with diagnoses including unspecified severe sepsis (a life-threatening blood infection) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Residentˆ72'sˆHistory and Physical (H&P) dated 12/10/2025, the H&PˆindicatedˆResidentˆ72ˆspeaks in full sentences, was able to make herˆown needs known and able to make simple medical decisions.ˆˆ During a review of Resident 72's Minimum Data Set (MDS - an assessment and care screening tool) dated 2/13/2026, the MDS indicated Resident 72 usually makes herself understood and usually understands others. The MDS further indicated Resident 72 needs substantial assistance (helper does more than half the work) with upper body and lower dressing, personal hygiene and putting on and taking off shoes. During an observation on 3/10/2026 at 9:51 a.m. in Resident 72's room, Resident 72 was up in the wheelchair with a bedside table in front of him halfway between his bed and the entrance door. Resident 72 lifted up his empty cup and made a gesture of wanting more. Resident 72's call light located on the bed, was out of his reach. During a concurrent observation and interview on 3/10/2026 at 9:57 a.m. inside Resident 72's room with Certified Nursing Assistant (CNA 1), CNA 1 stated she forgot to place the call light next to Resident 72. CNA 1 stated the call light should be next to Resident 72 to ensure he can communicate with facility staff, including making requests for water. During an interview on 3/13/2026 at 2:15 p.m., with the Director of Nursing (DON), the DON stated all call lights should be within each resident's reach so staff would be able to attend to their needs timely at all times. During a review of the facility's policy and procedure (P&P) titled, Answering the Call Light, last reviewed 4/16/2025, the P&P indicated staff must answer timely to the resident's request and needs. The P&P further indicated staff must ensure the call light is accessible to the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure the physician was notified when one of two sampled residents (Resident 94) repeatedly refused insulin (medication to lower blood sugar) injection. This deficient practice placed Resident 94 at risk for delayed care and poor blood glucose management, placing the resident at risk for health complications. Findings: Duringˆaˆreview of Residentˆ94'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted Resident 94 on 10/01/2023 and re-admitted the resident on 1/12/2025, with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), with diabetic polyneuropathy (nerve damage caused by diabetes that makes feet or hands feel numb, tingly, or painful), and peripheral vascular disease(a condition where blood vessels outside heart and brain usually in legs become blocked or narrowed, causing poor blood flow). ˆ During a review of Resident 94's History and Physical (H & P) dated 2/27/2026, the H&Pˆindicatedˆ Resident 94 does have the capacity to understand and make decisions on her own.ˆˆˆThe H&P indicated the Hemoglobin A1c (HbA1c, a blood test that shows your average blood sugar level over the past 2-3 months. The normal range is below 5.7 percent [%]) dated 8/21/2025 was 8.9%. The H&P indicated the HbA1c remains above goal, and the goal is less than 8%. During a review of Residentˆ94's Minimum Data Setˆ(MDS - a resident assessment tool), datedˆ1/02/2026,ˆthe MDS indicated Residentˆ94ˆhasˆintactˆcognition (mental action or process of acquiring knowledge and understanding) for daily decision. During a review of Resident 94's Physician Order Report dated 3/1/2026 to 3/10/2026, the Physician Order Report indicated the following order, with the start date of 3/21/2025. -Novolog(fast acting insulin) insulin 8 units; subcutaneous (under skin) for DM ; please rotate the site, hold if blood sugar less than 100 milligrams per deciliter(mg/dl, a unit of measurement to indicate how many milligrams of as glucose are present in one deciliter [100ˆmL] of blood), once a day, 7:30 a.m. During a review of Resident 94's Medication Administration Record (MAR) dated 3/01/2026 to 3/10/2026, the MAR indicated the following results for the Novolog 8 units subcutaneous order administered once daily at 7:30 a.m.: 3/1/2026 at 7:20 a.m. - Not Administered: Refused 3/4/2026 at 8:35 a.m. - Not Administered: Refused 3/5/2026 at 8:22 a.m. - Not Administered: Refused 3/6/2026 at 7:15 a.m. - Not Administered: Refused 3/7/2026 at 7:58 a.m. - Not Administered: Refused 3/9/2026 at 8:04 a.m. - Not Administered: Refused During a concurrent interview and record review on 3/10/2026 at 1:02 p.m., with the Director of Nursing (DON), Resident 94's Physician Order Report dated 3/01/2026 to 3/10/2026 was reviewed. The DON stated the order indicated thatˆResident 94 should receive insulin Novolog 8 units every morning at 7:30 a.m. The DON stated Resident 94 has a tendency to refuse insulin injections. During a concurrent interview and record review on 3/10/2026 at 1:10 p.m., with the DON Resident 94's MAR dated 3/01/2026 to 3/10/2026 was reviewed. The DON stated the MAR indicated thatˆResident 94 refused the scheduled Novolog injections at 7:30 a.m. on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026. The DON stated licensed nurses should have informed the physician that Resident 94 refused scheduled Novolog injections at 7:30 a.m. on those dates. The DON stated that it important to inform the physician when a resident refuses insulin so the physician can adjust the dose and help prevent complications such as high blood sugar or low blood sugar. During a concurrent interview and record review on 3/10/2026 at 1:17 p.m., with the DON, Resident 94's progress notes dated 3/1/2026 to 3/10/2026 was reviewed. The DON stated he was unable to find documented evidence that licensed nurses informed the physician that Resident 94 refused the scheduled 7:30 a.m. insulin injection on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026. During a concurrent interview and record review on 3/12/2026 at 8:18 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 94's MAR and progress notes dated 3/01/2026 to 3/10/2026 were reviewed. LVN 4 stated thatˆResident 94 refused the scheduled 7:30 am insulin injection on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/7/2026, and 3/9/2026. LVN 4 stated she is unable to find any documentation in the progress notes indicating the physician was informed of Resident 94's repeated refusal of insulin for 3/2026 .LVN 4 stated not notifying the physician had the potential to result in Resident 94 not receiving the right amount of medication which can lead to complications such as high blood sugar which could result in the resident experiencing increased thirst, headaches, blurredˆvision or low blood which could result in coma (deep state of unconsciousness where a person is not awake and cannot respond to their surroundings, including voice, touch, or pain), confusion or shakiness. LVN 4 further stated that notifying the physician will allow the physician to adjust the dose accordingly and determine an appropriate plan. During a concurrent interviewˆand record reviewˆonˆ3/11/2026ˆatˆ8:38ˆa.m.,ˆwithˆthe DON, the facility's policy and procedure (P&P) titled,ˆ Medication Administrationˆwas reviewed.ˆTheˆ Medication Administration, revised on 4/16/2025, indicated the DON and the attending physician must be notified when two consecutive doses of medication are refused or withheld. The DON stated that the licensed nurses should have notified the physician when Resident 94 refused insulin injection on 3/4/2026, 3/5/2026, 3/6/2026, and 3/7/2026 since the refusal occurred on consecutive days. The DON stated licensed nurses did not notify the physician and facility policy was not followed. The DON stated failure to notify the physician could result in the physician being unable to adjust the insulin accurately and the resident may not receive the right amount of insulin in the body. During aˆreview of the facility's P&P titled, Medication Administration, revised onˆ4/16/2025,ˆ the P&P indicatedˆmedications will be administered in a timely manner and as prescribed by the resident's/patient's attending physician or the facility's medical director. Charting Withholding/ Refusal of Medication on the MAR. Should a drug be withheld, refused, or given other than the schedules time, the individual administering the medication must initial and circle the MAR space provided for that particular drug. The Director of Nursing services and attending physician must be notified when two consecutive doses of medication are refused or withheld.

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	555846	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joyce Eisenberg Keefer Medical Center D/P Snf	7150 Tampa Avenue Reseda, CA 91335

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to safeguard resident confidentiality and privacy when a medication cart computer screen was left open and unattended on one of five medication carts (Medication Cart 3). This deficient practice had the potential to result in unauthorized disclosure of residents' personal information. Findings: During an observationˆonˆ3/9/2026 at 9:19 a.m.ˆin between the nursing station andˆmain dining room on the second floor of the facility,ˆobserved Team B medication cart unattended with the computer screen open to a resident's electronic Medication Administration Record (eMAR - a digital system to track and manage medication administration for resident). Registered Nurse (RN) 6 was observed calling out a name while approaching the medication cart, took steps to remove the eMAR from view on the screen and walked away from the medication cart. During an interview on 3/9/2026 at 922 a.m. with Registered Nurse (RN) 6, RN 6 stated she observed that the computer screen was left open displaying resident information and minimized the window screen (hide the screen) because of Health Insurance Portability and Accountability Act (HIPPA - US federal law designed to protect sensitive patient health information from disclosure without consent). RN 6 stated leaving the window open leaves residents' information to be seen by others. RN 6 stated she left the medication cart after minimizing the window screen to let the charge nurse know of the incident. During an interview on 3/9/2026 at 9:30 a.m. with Licensed Vocational Nurse (RN) 8, LVN 8 stated RN 6 informed her right away of her mistake of leaving the medication cart computer screen open. LVN 8 stated she should not have left the screen open displaying resident information because of HIPPA. LVN 8 stated that leaving the screen open had the potential for residents' personal information to be exposed and their privacy unprotected. During an interview on 3/12/2026 at 10:05 a.m. with the Director of Nursing (DON), the DON stated leaving a computer screen open to resident's medical record is a HIPPA concern. The DON stated leaving a computer screen open to a resident's medical record compromises privacy and confidentiality. During a review of the facility's policy and procedure (P&P) titled, Medication Administration last reviewed 4/16/2026, the P&P indicated, The MAR should be closed or covered when not attended to protect resident/patient confidentiality. During a review of the facility's P&P titled, Patient Protected Health Information last reviewed 4/16/2026, the P&P indicated, It is the policy of Los Angeles Jewish Health (LAJH) that all LAJH employees take every reasonable precaution in order to assure that patient protected information (PHI) is secure and will not be open to unwarranted exposure.LAJH employees using electronic devices will not leave them open for viewing and unattended should they be temporarily distracted by another duty. They will close the document and sign out of the software program. Screens should not be left open and unattended.

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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 a safe, clean, comfortable, and homelike environment for two of five sampled residents (Residents 95 and 111) when the carpet in the residents' shared room was in disrepair. This deficient practice denied Residents 95 and 111 the right to a safe and homelike environment and had the potential to negatively impact their quality of life. Findings: During a review of Resident 95's Face Sheet, the Face Sheet indicated the facility admitted the resident on 1/1/2022 with diagnoses including, but not limited to, Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities). During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool), dated 1/26/2026, the MDS indicated the resident had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) skills necessary for daily decision making and never or rarely made decisions. The MDS indicated Resident 95 was dependent (helper does all of the effort) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 111's Face Sheet, the Face Sheet indicated the facility admitted the resident on 9/18/2023 with diagnoses including, but not limited to, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 111's MDS, dated [DATE], the MDS indicated the resident had severely impaired cognitive skills necessary for daily decision making and never or rarely made decisions. The MDS indicated Resident 111 was dependent on staff for all ADLs. During a concurrent observation and interview on 3/9/2026 at 10:32 a.m. with Resident 95's family member (FM 2) in Resident 95 and Resident 111's shared room, an area of the carpet had a linear cut in a rectangular shape with three cut sides. FM 2 stated someone had put tape over the cut area but now the tape was old and the whole area did not look nice. FM 2 put her foot in the cut area of the carpet and lifted part of the carpet up. FM 2 stated someone could trip on the carpet. FM 2 stated the carpet had been this way for at least two years. FM 2 stated someone from the facility had told her in the past it would be replaced but they never did it. During a concurrent observation and interview on 3/11/2026 at 3:10 p.m. with the Maintenance Manager (MM) in Resident 95 and Resident 111's shared room, the MM observed and validated the carpet was cut and the tape was missing over parts of the cut area. The MM observed and validated the cut area of the carpet could be lifted. The MM stated someone could trip in this area, the carpet does not look like it should, and the tape looked worn and peeling. During an interview on 3/12/2026 at 9:12 a.m. with the Director of Nursing (DON), the DON stated although the residents in the room were unable to walk, someone like a staff member could trip on that area of carpet. The DON stated the carpet does not look nice. During a concurrent observation and interview on 3/12/2026 with the MM, the MM stated the cut area in the carpet was approximately four by two-and-a-half feet. During a review of the facility's policy and procedure (P&P) titled, Accommodation of Needs, last reviewed 4/16/2025, the P&P indicated in order to create an individualized, homelike environment, each resident has the right to resident and receive services in the facility with reasonable accommodation or resident needs and preferences. During a review of the facility's policy and P&P titled, Work Environment, last reviewed 4/16/2025, the P&P indicated a safe and healthful work environment will be provided for all employees, residents, and visitors.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its grievance policy and procedure for one out of two residents (Resident 222) when the facility failed to assist Resident 222's family member in filing a grievance related to the care provided to Resident 222 by Certified Nursing Assistant (CNA) 5 and failed to conduct an investigation into the concerns. This deficient practice violated Resident 222's right to have a grievance addressed, had the potential to negatively affect Resident 222's care, and had the potential to cause Resident 222 to feel invalidated and disrespected. Findings: During a review of Resident 222's Face Sheet, the Face Sheet indicated the resident was admitted on [DATE] with diagnoses including, but not limited to, rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), and dementia (a progressive state of decline in mental abilities). During a review of Resident 222's Minimum Data Set (MDS - a resident assessment tool), dated 1/31/2026, the MDS indicated the resident had moderate cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 222 was dependent (helper does all the effort) on staff for lower body dressing and putting on footwear. The MDS indicated Resident 222 required substantial assistance (helper does more than half of the effort) with upper body dressing and toileting. The MDS indicated Resident 222 required partial assistance (helper does less than half of the effort) with personal hygiene. The MDS indicated Resident 222 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) with oral hygiene and bathing. During a review of the Tracking Log for Issues and Concerns, dated March 2025 to February 2026, the log did not indicate a grievance, issue, or concern was logged involving Resident 222. During an interview on 3/9/2026 at 11:05 a.m. with Resident 222, Resident 222 stated that CNA 5 had spoken in ways that were not nice to her in the past. Resident 222 stated a few months ago after using the bathroom she asked CNA 5 to help her pull up her brief (a high-absorbency incontinence garment). Resident 222 stated CNA 5 then told her she could do that herself and then called her lazy. Resident 222 stated her family member had reported this to the social worker. During a telephone interview on 3/9/2026 at 2:28 p.m. with Family Member (FM) 1, FM 1 stated she sent an email in September 2025 to Social Worker (SW) 1 informing her that CNA 5 was unkind to Resident 222 and had called her lazy. FM 1 stated no one from the facility had followed up with her after her email. FM 1 stated she sent another email on 3/8/2026, and today (3/9/2026) CNA 5 was no longer assigned to provide care to Resident 222. During an interview on 3/9/2026 at 3:47 p.m. with the facility administrator (ADM), the Director of Social Services (DSS), and Registered Nurse (RN) 7, the ADM stated FM 1 had emailed SW 1 about this concern in September 2025, but SW 1 was no longer employed at the facility. RN 7 stated she became aware of FM 1's concern when SW 1 told her about it in September 2025. RN 7 stated she spoke to CNA 5, and CNA 5 stated she never called Resident 222 lazy. The DSS stated she became aware of FM 1's concern this morning (did not specify time) when she read the email FM 1 sent last night. The DSS stated she was not aware of the email FM 1 sent to SW 1 in September 2025. The ADM stated there was no grievance filed in September 2025 when FM 1 sent the first email. The ADM stated the best practice would have been to file a grievance at that time. During an interview on 3/10/2026 at 4:04 p.m. with FM 1 and Resident 222, FM 1 stated when she sent the email in September 2025, she was not informed of the facility's grievance process or how to file a grievance. Resident 122 stated she was not aware of how to file a grievance. Resident 222 stated her interaction with CNA 5 was upsetting and made her feel uncomfortable. During an interview on 3/12/2026 at 2:47 p.m. with the ADM, the DSS, and RN 7, RN 7 stated after she was made aware of FM 1's concern in September 2025, she spoke to CNA 5 but did (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not speak to FM 1 or Resident 222. RN 7 stated she was not aware if anyone had spoken to FM 1 or Resident 222 to follow up on the concern. The ADM stated once they are aware of a concern they should go to the source, listen fully to the concern, and validate them. The ADM stated they should follow their proper process to address their concerns, make sure the resident feels safe, and ensure that they are treated in a respectful and dignified way. The ADM stated she would have expected SW 1 to forward FM 1's concern to the DSS who was her supervisor, then interview FM 1 and ask clarifying questions. The ADM stated she would then expect SW 1 to speak directly with Resident 222 to hear her experience and ask what she would like to be done and if she would like a different CNA to be assigned to her. The DSS stated all of these actions should have been documented and the facility's Issues and Concerns form should be filled out. The DSS stated when she learned of the concern on 3/9/2026 she completed an Issues and Concerns form. The ADM stated the resident could potentially have felt unheard, invalidated, not respected, or not believed. During a review of the facility's policy and procedure (P&P) titled, Issues and Concerns Process, last reviewed 4/16/2025, the P&P indicated the following: a. Grievances are referred to as Issues and Concerns for the purpose of the policy and the form associated with it. b. The facility with assist residents, their representatives, and other interested family members in filing issues or concerns when such requests are made. c. Issues and concerns can be submitted orally or in writing. d. Once a verbal or written issue or concern is received the respective department will investigate allegations and submit a written report to the administrator. e. The person filing the issue or concern will be informed of the findings of the investigation and the action that will be taken to correct any identified problems. f. If the resident or their representative is not satisfied with the result of the investigation or recommended actions they can appeal to the administrator or compliance officer. g. Records of grievances will be maintained for three years.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. Based on interview and record review, the facility failed to ensure a resident's Minimum Data Set (MDS) annual assessment was transmitted to Centers for Medicare and Medicaid Services (CMS, a federal government agency that manages the Medicare and Medicaid programs, which provide health coverage to people) within the required 14 day timeframe for one of one sampled residents (Resident 87) reviewed under the resident assessment facility task. This deficiency prevents the CMS from having the most accurate information of Resident 87 and had the potential to result in delayed services for the resident. Findings: During a review of Residentˆ87'sˆFace Sheet,ˆtheˆFace Sheet indicated the facility admitted Residentˆ87ˆonˆ3/23/2025ˆwith diagnoses includingˆchronic obstructive pulmonary disease (COPD - a progressive, long-term lung disease that makes it hard to breathe by restricting airflow), major depressive disorder (a mental health condition with persistent feelings of sadness and hopelessness.) and ileostomy (a surgical opening that lets stool pass from your body without going through your colon) ˆˆ During a review of Residentˆ87's Minimum Data Set (MDS - an assessment and care screening tool) datedˆ1/11/2026,ˆthe MDS indicated the Resident 87 makes himself understood and understood others. The MDS furtherˆindicatedˆResidentˆ87ˆneeded partial assistance (helper does less than half the effort) with toileting, upper body dressing, lower body dressing, putting on/taking off shoes and personal hygiene. ˆ During a review of Resident 87's Final Validation CMS Submission Report titled MDS 3.0 Final Validation Report, printed on 3/12/2026, the report indicated Resident 87's assessment was submitted and processed on 3/11/2026 at 15:08 (3:08 p.m.). The MDS was completed on 1/11/2026 but not transmitted until 59 days later on 3/11/2026. During aˆconcurrentˆinterviewˆand record reviewˆon 3/11/2026 atˆ11:45ˆa.m. with Minimum Data Set Coordinator 3ˆ(MDSC 3), MDSC 3 reviewed Resident 87's annual assessment. MDSC 3 stated once the annual assessment is complete, it must be transmitted to CMS within 14 days to ensure CMS has the most updated and accurate information on each resident. MDSC 3 stated he forgot to validate and submit Resident 87's assessment after it was completed. During an interview on 3/12/2026 at 1:32 p.m. with the Director of Nursing (DON), the DON stated MDS annual assessments must be completed on time and then submitted to CMS within 14 days. The DON stated Resident 87's annual assessment was submitted 59 days after completion and about 45 days too late. ˆThe DON stated it is important to submit the MDS annual assessments timely to ensure CMS has the most accurate information on each resident. During a review of the facility providedˆPolicy and Procedure (P&P)ˆtitled, Transmitting MDS Data, last reviewed on 4/16/2025, the P&Pˆindicatedˆthatˆafterˆtheˆcompletionˆofˆtheˆrequiredˆassessmentˆand/orˆtrackingˆrecords,ˆeachˆproviderˆmustˆcreateˆelectronicˆtransmissionˆfilesˆthatˆmeetˆtheˆrequirementsˆdetailedˆinˆtheˆcurrentˆMDSˆ3.0ˆDataˆSubmissionˆSpecifications.ˆDuringˆaˆreviewˆofˆtheˆfacilityˆprovidedˆP&Pˆtitled,ˆMinimumˆDataˆSetˆ-ˆResidentˆAssessmentˆInstrument,ˆlastˆreviewedˆonˆ4/16/2025,ˆtheˆP&PˆindicatedˆtheˆMDSˆcoordinatorˆmustˆtransmitˆtoˆtheˆstateˆrepositoryˆinˆaccordanceˆwithˆCMSˆestablishedˆrecordˆspecificationsˆandˆtimeˆframes.

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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 ensure the interdisciplinary team (IDT- a collaborative approach where healthcare professionals from various disciplines work together to provide comprehensive patient care) reviewed and revised a resident's care plan to include appropriate interventions addressing the resident's refusal of prescribed insulin injections for one of two (Resident 94) sampled residents. This deficient practice had the potential to result in failure to deliver the necessary care and services to Resident 94. Findings: Duringˆaˆreview of Residentˆ94'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted Resident 94 on 10/01/2023 and re-admitted resident on 1/12/2025, with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), with diabetic polyneuropathy (nerve damage caused by diabetes that makes feet or hands feel numb, tingly, or painful), mild cognitive impairment(mild thinking or memory problems) of uncertain or unknow etiology (illness), and peripheral vascular disease(a condition where blood vessels outside heart and brain usually in legs become blocked or narrowed, causing poor blood flow). ˆ During a review of Resident 94's History and Physical (H & P) dated 2/27/2026, the H&Pˆindicatedˆ Resident 94 does have the capacity to understand and make decisions on her own.ˆˆˆ During a review of Residentˆ94's Minimum Data Setˆ(MDS - a resident assessment tool), datedˆ1/02/2026,ˆthe MDS indicated Resident 94's cognition (relating to or involving the processes of thinking and reasoning)ˆis intact. During a review of Resident 94's Care Plan (CP) updated on 1/6/2026 titled Episodes of non-compliant with medications-insulin, the CP goal indicated the resident will participate in tasks and demonstrate a level of compliance that does not interfere with quality of care needed to maintain the safety and well-being of the resident. The CP indicated the following interventions: - Break into small steps, be patient and allow ample time or try again later. Simplify the request. Ask yes/no questions. Respect request for privacy. Reassure, comfort and distract when appropriate. Provide explanation as to benefits and risks for treatment/medication/plan of care. - Review what constitutes compliance/best interests. - Allow for time to review information given and ask if there is a better time/another day this can be reviewed again. Involve family/significant others as needed. -Accept/support decision to refuse/deny care. -Notify the primary physician of decision and review options if available. (unchecked) During a review of Resident 94's Physician Order Report dated 3/1/2026 to 3/10/2026, the Physician Order Report indicated the following order, with the start date of 3/21/2025. -Novolog(fast acting insulin) insulin 8 units; subcutaneous (under skin) for DM ; please rotate the site, hold if blood sugar less than 100 milligrams per deciliter(mg/dl, a unit of measurement to indicate how many milligrams of as glucose are present in one deciliter [100ˆmL] of blood), once a day, 7:30 a.m. During a review of Resident 94's Medication Administration Record (MAR) dated 3/01/2026 to 3/10/2026, the MAR indicated the following results for the Novolog 8 units subcutaneous order administered once daily at 7:30 a.m.: 3/1/2026 at 7:20 a.m. - Not Administered: Refused 3/4/2026 at 8:35 a.m. - Not Administered: Refused 3/5/2026 at 8:22 a.m. - Not Administered: Refused 3/6/2026 at 7:15 a.m. - Not Administered: Refused 3/7/2026 at 7:58 a.m. - Not Administered: Refused 3/9/2026 at 8:04 a.m. - Not Administered: Refused During a concurrent interview and record review on 3/10/2026 at 1:02 p.m., with the Director of Nursing (DON), Resident 94's Physician Order Report dated 3/01/2026 to 3/10/2026 was reviewed. The DON stated the order indicated thatˆResident 94 should receive insulin Novolog 8 units every morning at 7:30 a.m. The DON stated Resident 94 has a tendency to refuse insulin injections. During a concurrent interview and record review on 3/10/2026 at 1:22 p.m., with the DON Resident 94's CP titled Episodes of non-compliant with medications-insulin, dated 1/6/2026 was reviewed. The DON stated Resident 94's care plan was not resident specific as it lacked critical information related to the resident's refusal. The DON stated the CP did not include parameters for escalation such as the number of missed doses requiring notification, the frequency (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for monitoring refusals, or defined blood sugar levels that would require physician notification. The DON further stated that the section indicating notify physician of decision and review options if available was unchecked, indicating this intervention had not been incorporated into the resident's CP. During a concurrent interview and record review on 3/10/2026 at 1:32 p.m., with the DON Resident 94's IDT/Care Plan with observation date of 1/6/2026 and completion date of 3/10/2026, was reviewed. The DON stated the IDT meeting care plan review did not address Resident 94 ?s repeated refusals of insulin administration. The DON also stated that this issue should have been discussed during the IDT/Care Planning meeting to establish appropriate interventions. During a concurrent interview and record review on 3/12/2026 at 8:22 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 94's CP titled Episodes of non-compliant with medications-insulin, dated 1/6/2026 was reviewed. LVN 4 stated thatˆResident 94's care plan was not resident specific, as the CP did not indicate when the physician should be notified, the number of refusals requiring notification, and acceptable blood glucose parameters. LVN 4 stated she believed the physician should be notified after three refusals. During aˆreview of the facility's policy and procedure (P&P) titled, Inter-disciplinary Risk meeting, revised onˆ4/16/2025, the P&P ˆindicatedˆthe Risk meeting is designated to bring current resident/patient care issues to the Interdisciplinary Team (IDT) for discussion, potential alterations to the plan of care, notification to all disciplines regarding current status of residents/patients, and to develop proactive approaches designed to prevent acute episodes from occurring. During aˆreview of the facility's P&P titled, Care Plans, Comprehensive, revised onˆ4/16/2025, the P&Pˆindicatedˆanˆindividualized comprehensive care plan that includes measurable objectives and timetables to meet the resident/patient's medical, nursing, mental and psychological needs is developed for each resident/patient. Our facility's care planning/interdisciplinary team, in coordination with the resident/patient his/her family or representative (sponsor), develops and maintains a comprehensive car plan for each resident. Each resident/patient's comprehensive care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident/ patient's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care;

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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: 1.Clarify with the physician the basis for determining the appropriate setting for a resident's low air loss mattress (LALM - designed to distribute a patient's body weight over a broad surface area and help prevent skin breakdown) in accordance with the facility policy for one (Resident 4) out of two sampled resident investigated for pressure ulcer/injury (a skin and soft tissue injury that occurs when skin is under pressure). This deficient practice placed the resident at risk of discomfort and development of new pressure ulcers (areas of damaged skin and tissue caused by sustained pressureˆthat reduces blood flow to vulnerable areas of the body). 2. Completeˆaˆskinˆassessmentˆfor one of two sampled residentsˆ(Resident 1)ˆreviewed for pressure ulcer/injury when Resident 1's skinˆimpairment was re-classifiedˆfromˆStage 2 pressureˆinjuryˆ(PIˆ-ˆinjuryˆto the skin and underlyingˆtissue resulting from prolonged pressure on the skin)ˆto MoistureˆassociateˆSkinˆDamage (MASDˆ-ˆskin erosionˆcaused by prolonged exposure to source of moisture suchˆas urine, stool, seat, wound drainage, saliva or mucus).ˆ This deficient practiceˆhad the potential toˆplace Resident 1 at riskˆfor inappropriateˆinterventions, incorrectˆtreatment, and potential worsening ofˆskin integrity.ˆ Findings: 1.During a review of Resident 4's Face Sheet, the Face Sheet indicated the facility originally the resident to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia (ˆa general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and seizures (a sudden burst of electrical activity in the brain). During a review of Resident 4`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 02/06/2026, indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and 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 03/09/2026 at10:49 a.m., observed Resident 4 in bed sleeping on a low air loss mattress set at 210 pounds.ˆ During a concurrent interview and record review on 03/11/2026 at 8:32 a.m., with Licensed Vocational Nurse 6 (LVN 6), Resident 4`s physician`s order and current weight was reviewed. The review indicated that there was an order for a LALM for wound prevention on 3/6/2026, however it did not specify the basis for determining the setting for the LALM. LVN 6 stated Resident 4's current weight is 171 pounds (lbs.-unit of weight). LVN 6 stated that the LALM is used for skin management and to prevent skin breakdown for resident that are always in bed. LVN 6 stated a LALM is set according to the resident`s weight and the higher the setting the harder and firmer the mattress becomes, which can potentially result in the development of a wound. During a concurrent observation and interview on 3/11/2026 at 8:45 a.m., in Resident 4's room with LVN 6, observed Resident 4 lying on a LALM set at 210 lbs. LVN 6 stated that the setting of 210 lbs. is not accurate and she will obtain a physician order to determine the appropriate setting for Resident 4's LALM. (continued on next page)

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	555846	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 03/12/2026 at 9:08 a.m., with the DON stated the use of air loss mattress can prevent the development of skin impairment and if the setting is incorrect, it will not achieve the intended therapeutic effect but rather can be the cause of the pressure ulcer.ˆ ˆ During a review of the facility`s policy and procedure (P&P) titled Patient/Resident Pressure Redistribution Devices-Air Loss Mattress, last reviewed on 4/16/2025, the P&P indicated that it is the policy of this facility that all residents/patients utilizing an air loss mattress will be monitored appropriately to ensure pertinent and effective use and cleaning. During a review of the Air Loss Mattress Operation Manual (OM) provided by the facility, the OM indicated that users can adjust air mattress to a desired firmness according to patient`s weight or the suggestion from a health care professional. 2.ˆDuring a review of Resident 1'sˆFace Sheet, theˆFace Sheetˆindicatedˆthe facility admitted Resident 1 to the facility onˆ01/10/2026, with diagnoses includingˆbacterial pneumonia (serious lung infectionˆcaused byˆbacteria),ˆchronic respiratory failureˆ(long-term condition where the lungs cannot sufficiently transfer oxygen into the blood) andˆtype 2 diabetes mellitusˆ(a chronic condition that affects the way the body processes blood sugar).ˆ During review of the History and Physical (H&P) report completed onˆ1/13/2026, the H&Pˆindicatedˆ Residentˆ1ˆis ableˆtoˆmake her own needs known andˆhas the capacity toˆmake her own medical decisions.ˆ During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1ˆisˆable toˆmake self-understood and able to understand others. The MDS indicated Resident 1 was dependent (helper doesˆall ofˆthe effort) withˆtoileting hygieneˆand substantial maximalˆassistanceˆ(helper does more than half the effort)ˆforˆpersonal hygiene,ˆshower/bathe self, upper and lower body dressing. The MDS indicated that Residentˆ1ˆis dependent forˆchair/bed-to-chair transfer, tub/shower transfer,ˆand substantial/maximal assistˆforˆroll left and right (ability to roll from laying on back to left and rightˆside andˆreturn to laying on back on the bed).ˆ During an interview on 3/9/2026 at 9:46 a.m. with Resident 1,ˆResident 1ˆstatedˆsheˆhasˆbowel and bladder incontinenceˆ(losing control over passing stool or urine, leading toˆaccidental leakage).ˆResident 1ˆstated that her medication makes her urinate often, and she had several days of diarrhea. Resident 1ˆstatedˆthat theˆfrequent urination andˆrecentˆloose stools haveˆcaused herˆto have sores on her buttocks.ˆ During a concurrent interview and record review onˆ3/11/2026 atˆ12:50 p.m., withˆthe Minimum Data Setˆ Coordinatorˆ(MDSC) 1, Residentˆ1's Wound Management datedˆ3/2/2026, Progress Notes dated 3/2/2026-3/3/2026, andˆPhysicianˆOrdersˆdated 3/11/2026 were reviewed.ˆMDSC 1ˆstatedˆthat it is theˆRegisteredˆNurse's (RN) responsibility to perform a comprehensive skin assessment during admission and as needed, such as when a resident develops impaired skin integrity.ˆDuring review ofˆtheˆWound Managementˆformˆdated 3/11/2026,ˆthe formˆindicatedˆResident 1 had aˆpressure injury to right buttocksˆmeasuring 1.5 centimeters (cm-unit of measurement) x 1.4 cm xˆ0.2 cm.ˆDuring review ofˆResident 1's currentˆtreatment orders,ˆtheˆphysician's ordersˆdated 3/3/2026ˆindicatedˆtreatment ordersˆforˆMASDˆto the right buttocks.ˆ MDSC 1ˆstatedˆthatˆthe wound wasˆlikely re-assessedˆandˆdetermined to be MASD and not a PI. MDSC1ˆstated (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pain assessment and changes in conditionˆe.g.ˆinfection or otherˆpossible complicationsˆ During a review of the facility'sˆHealth Information Record Manualˆtitled, Chapter III 3025 Documentation Guidelines last reviewedˆ4/16/2025, theˆrecordˆindicated,ˆ3.ˆDocumentation in the legal health record will followˆthese basic rules: .Record applicable observations,ˆpsychosocial and physical manifestations, incidents, unusual occurrences, and abnormal behavior.Promptly recordˆas the events or observations occur; complete, concise, descriptive, factual, and accurately describe services providedˆto/for the resident.ˆˆ

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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: 1.Ensure one of five sampled residents (Resident 40) reviewed for accidents, was safely transferred from bed to wheelchair using the sit-to-stand lift (Sara lift, a mechanical device that helps lift a resident to rise from a seated position. This requires a resident to be able to support at least partial body weight while standing) with a two-person assist in accordance with the facility policy. This deficient practice had the potential to place Resident 40 at risk for fall. 2. Ensure prepared medication was not left unattended on one of five medication carts (Medication Cart 2). This deficient practice had the potential to result in accidental ingestion of medication and can lead to adverse reactions (any unexpected or dangerous reaction to a drug). Findings: 1. During a review of Resident 40's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included dysphagia (difficulty swallowing), attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 40' s Minimum Data Set (MDS, a resident assessment tool), dated 1/01/2026, the MDS indicated Resident 40 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 40 was dependent (helper does all the effort) on staff for chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). During a review of Resident 40's Physician's Orders, the orders indicated: Sara lift with two-person assist (sic) [a Latin adverb that is used to note when a quotation may not be correct in terms of spelling or grammar] on all transfers, dated 11/20/2024. During a review of Resident 40's Care Plan for Falls, initiated 3/19/2021, the care plan indicated a goal that there will be a reduced risk for falls daily for 90 days. The care plan indicated an intervention for Sara lift with two-person assist on all transfers. During a review of Resident 40's Falls Risk Assessment, dated 12/31/2025, the assessment indicated the resident was at a high risk for falls. During an observation on 3/12/2026 at 7:30 a.m., observed CNA 4 opening Resident 40's room door and exiting pushing a Sara lift. CNA 4 stated she moved Resident 40 from bed to wheelchair with the Sara lift. When asked if she had assistance with the transfer from another staff member, she stated Registered Nurse 5 (RN 5) assisted her. During an interview with RN 5 on 3/12/2026 at 7:37 a.m., she stated she did not help CNA 4 with any task that morning as she walked in the hallway and stopped in front of Resident 40's room. CNA 4 stated RN 5 assisted her with the Sara lift and RN 5 stated she did assist CNA 4. When asked why RN 5 stated she had helped CNA 4 when a moment ago she said she did not help her, RN 5 stated she did (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not help CNA 4 to transfer Resident 40 from bed to wheelchair using the Sara lift. Then CNA 4 stated she used the Sara lift by herself without help from any staff. CNA 4 stated she should have asked another staff member to help her because it is important for someone to be standing by to ensure the Sara lift is locked and the wheelchair does not move. RN 5 stated two staff should operate the Sara lift, to ensure the safety of the move and to prevent injury. RN 5 stated one person transfer with the Sara lift could place a resident at risk for fall. During a concurrent interview and record review with the Director of Nursing (DON) on 3/12/2026 at 8:15 a.m., the DON reviewed the facility's policy and procedure titled, Moving/Positioning a resident/patient, last reviewed 4/16/2025. The DON referred to the portion of the policy that indicated: to ensure that there is a second person to assist in the use of Hoyer lifts (electric medical device designed to safely transfer individuals with limited mobility between beds, chairs, and wheelchairs, which would include Sara lift). The DON stated this referred to a Sara lift also. The DON stated the Sara lift should always have two staff members present for resident transfer. The DON stated it is their policy, for safety, to prevent any possible injury. During a review of the facility's policy and procedure titled, Moving/Positioning a resident/patient, last reviewed 4/16/2025, the policy indicated in the section titled, Hoyer/Sara lifts: Ensure that you have a second person to assist in the use of Hoyer lifts. 2. During an observation on 3/9/2026 at 9:19 a.m. in between the nursing station and main dining room on the second floor of the facility, a medication cup filled with pasty substance and a spoon inside the cup was observed resting on the unattended Medication Cart 2. During an interview on 3/9/2026 at 9:30 a.m. with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated she prepared the medication for a resident and left it on the medication cart when she went to another resident's room. LVN 8 stated she left the medication on the cart so she could inform another resident about their upcoming beauty salon visit later that day. LVN 8 stated there was no urgent need to let the resident know about her visit to the beauty salon. LVN 8 stated she should not have allowed herself to get distracted and be interrupted from administering the medication she had prepared for the resident. LVN 8 stated I know my mistake. We have to only be doing medications when doing medications. LVN 8 stated she was multi-tasking when she should be concentrated on medication pass (a structure process used in long-term facilities to ensure residents receive their medication safely and accurately). LVN 8 stated medication should be administered immediately after preparation. LVN 8 stated that if there was a valid reason that interrupts her during medication pass such as an emergency, the medication must be stored securely to prevent access by other residents for safety reasons. During an interview on 3/12/2026 at 10:05 a.m. with the DON, the DON stated medication should never be left unattended due to the potential risk of other residents ingesting medication not prescribed for them. The DON stated medications must be securely maintained to protect resident safety. During a review of the facility's P&P titled, Medication Administration last reviewed 4/16/2026, the P&P indicated Security of medication care during medication pass: No medication are kept on top of the cart. During a review of the facility's P&P titled, Drug Storage/Inventory Inspection last reviewed 4/16/2026, the P&P indicated Drugs on the unit will be kept in locked medication carts or in locked medication rooms with access to licensed nursing and pharmacy personnel only.Drugs shall be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	accessible only to licensed personnel designated by the medical center. During a review of the facility's P&P titled, Accident and Resident Safety Reporting last reviewed 4/16/2026, the P&P indicated The facility provides management to support environment, training, assessment and action(s) planned as needed to keep residents as free as possible from accidents, hazards, breaches of personal identified information, infections, communicable/pandemic diseases over which the facility has control.Hazards refer to elements of the residents environment that have the potential to cause injury or illness.Free of accidents hazards as is possible refers to being free of accident hazards over the facility has control.Resident environment includes the physical surrounding to which the resident has access (e.g. room, unit, common areas, and facility grounds, etc.).

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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 complete a resident's Hemodialysis (HD, the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) Record withˆ information including assessment of the arteriovenous fistula (AVF- a surgically created connection, typically between an artery and a vein in the forearm or upper arm, with the non-dominant arm preferred) for bruit and thrill (you can feel for a thrill at the fistula incision site. A thrill feels like buzzing under your skin. Theˆbruit and thrillˆtell you that your fistula is working) for one of one (Resident 16) resident investigated under the Dialysis care area. This deficient practice placed the resident at risk for complications such as thrombosis (blood clot), stenosis (narrowing), or reduced blood flow, resulting in loss of access, infection, and inadequate dialysis treatment. Findings: During a review of Resident 16's Face Sheet, the Face Sheet indicated the facility originally admitted the resident to the facility on [DATE] with diagnoses including end stage renal disease (when kidneys no longer function well enough to meet a body's needs) and type 2 Diabetes Mellitus (when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 16`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 02/25/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and the resident required supervision and touching assistance (helper provides verbal cues) for oral hygiene, upper body dressing, personal hygiene and substantial/maximal assistance (helper does more than half the effort for toileting hygiene and shower. During a review of Resident 16's Physician Order dated 02/11/2025 to 03/11/02025, the Physician Order indicated an order for dialysis every Tuesday-Thursday-Saturday at 11:30 a.m. chair time (refers to the time spent sitting in a dialysis chair during a dialysis treatment, whichˆtypically lasts around 3-4 hours). During a review of Resident 16`s Hemodialysis Record on 03/11/2026 at 10:11 a.m. with Licensed Vocational Nurse 6 (LVN 6), the record did not have documented evidence that an assessment for the presence of bruit and thrill was conducted on the following dates: 02/03/2026 02/05/2026 02/07/2026 02/09/2026 02/12/2026 02/14/2026 02/17/2026 02/19/2026 02/21/2026 02/24/2026 02/26/2026 02/28/2026 LVN 6 stated that the AVF must be assessed before and after dialysis treatments to ensure that the fistula is patent and not clotted and to monitor for signs and symptoms of infection. LVN 4 further stated that routine pre and post dialysis assessments are necessary to promptly identify concerns, such as absence of bruit or thrill or signs of infection, and to ensure timely notification of the physician to prevent missed dialysis treatments. LVN 4 also stated the hemodialysis record serves as a communication tool between nursing staff and the dialysis provider, including documentation of the AVF status to ensure continuity of care. During a review of the facility policy and procedure (P&P) titled, Dialysis Care, last reviewed 4/16/2025, the P&P indicated that the facility shall facilitate arrangements for ongoing dialysis care as ordered by the physician.IDT [An Interdisciplinary Team (IDT) in nursing isˆa collaborative group of healthcare professionals-including nurses, physicians, social workers, and therapists-who work together to create and implement a comprehensive care plan for patients] shall assure that the resident`s/patient`s treatment plan includes resident`s/patient`s renal condition and necessary precautions i.e. shunt site, weights, dietary and fluid restrictions.observe for signs and symptoms of infection.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, interview and record review the facility failed to ensure that staffing information, including the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, was posted daily for two of two days (3/9/2026 and 3/10/2026), in accordance with the facility's policy and procedure (P&P) on Administrative Manual. This deficient practice resulted in the total number of staff and the actual hours worked by the staff in the facility were not readily accessible to residents, staff and visitors. Findings: During an observation on 3/10/2026 at 2:30 p.m., a nurse staffing information posted near the lobby nursing station was dated 3/9/2026, and did not indicate the resident census, the total number and the actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistant s from 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m. During a concurrent observation and an interview with Registered Nurse 2 (RN 2) on 3/10/2026 at 2:33 p.m., observed nurse staffing information posted near the lobby nursing station. RN 2 stated that the nurse staffing information posting was dated 3/9/2026. RN 2 stated the staffing information was missing the actual resident census and the actual total hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants from 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m. RN 2 stated that the nursing staffing information should be posted daily and updated every shift so residents, family members, and staff can see the number of hours available for resident care. During an interviewˆand record reviewˆonˆ3/10/2026ˆatˆ3:35ˆp.m.,ˆwith the Executive Administrative Assistantˆ(EEA), JEKMC Nursing Censusˆdated 3/9/2026ˆand timedˆ3:47 p.m.; signedˆon 3/10/2026 at 3:47 p.m.ˆwasˆreviewed. The EEAˆstatedˆthat the facility's nursing staffing information should be posted and updated daily at the beginning of each shift to inform the public the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistant every shift. The EAA stated that the nursing staffing information for 3/10/2026 should have been posted by the night shift charge nurse to ensure the staffing information was visible to all staff, residents and visitors prior to the to the start of the morning shift (7 a.m.-3 p.m.). During an interviewˆand record reviewˆonˆ3/11/2026ˆatˆ8:33ˆa.m.,ˆwithˆDirector of Nursing (DON),ˆthe facility's policy and procedure (P&P) titled,ˆ Administrativeˆ Manualˆwas reviewed.ˆTheˆDON stated that the nurse staffing dataˆshould be posted dailyˆat the beginning of each shift, including resident census and theˆtotal numberˆand actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. ˆThe DONˆstatedˆthat facility policy was not followed, resulting in residents, staff and visitors being unable toˆdetermineˆhow many staff worked on 3/9/2026 or who was scheduled to work on 3/10/2026.ˆ ˆ During aˆreview of facility's (P&P) titled, Administrative Manual, revised onˆ4/16/2025,ˆthe P&P indicatedˆthe facility willˆpost the nurse staffing dataˆdailyˆat theˆbeginningˆof eachˆshift.ˆData will be posted clear and redˆable format and in a prominent place readily accessible toˆresidentsˆand visitors the posting will include theˆtotal numberˆand actual hoursˆworkedˆby the following categories of licensed and licensedˆnursing staff directly responsible for resident care per shiftˆRegisteredˆnurse, License practicalˆnurse, certifiedˆnurseˆassistantˆandˆresidentˆcensus.ˆˆ

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	555846	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joyce Eisenberg Keefer Medical Center D/P Snf	7150 Tampa Avenue Reseda, CA 91335

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of four residents received the correct form of medication in accordance with the physician's order when one of four sampled residents (Resident 216), who had an order for lactobacillus acidophilus (probiotic/supplement medication) in capsule form was administered the tablet form during the medication pass observation. This deficient practice had the potential to alter the medication absorption and effectiveness, resulting in suboptimal treatment or increased risk of adverse effects (unwanted or harmful reaction to a medication or treatment).Findings: During a review of Resident 216's Face Sheet (FS), the Face Sheet indicated the facility Resident 216 was originally admitted on [DATE] and was re-admitted on [DATE] with diagnoses including acute respiratory disease (condition in which your blood does not get enough oxygen or has too much carbon dioxide), chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure) and chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe). During review of Resident 216's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 12/19/2025, the MDS indicated Resident 216 has intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required mostly maximal (helper does more than half the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 216's Physician Order Report, the Physician Order Report, indicated an order dated 7/29/2024 for lactobacillus acidophilus (probiotic/supplement medication) 100 milligrams (mg-unit of measurement) one capsule orally once a day. During a concurrent observation, interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 3/10/2026 at 8:43 a.m. Resident 216' s Medication Administration Record (MAR) was reviewed. Resident 216's MAR indicated to administer lactobacillus acidophilus 100 mg one capsule orally. During the medication pass observation, observed LVN 1 remove one tablet from the lactobacillus tablet medication container and administer the medication orally to Resident 216. LVN 1 stated that the facility only carried house supply of lactobacillus in tablet form and did not have the capsule form available. During an interview on 3/12/2026 at 9:20 a.m. with the Director of Nursing (DON), the DON stated that he was not aware that the facility does not carry house supply of lactobacillus in capsule form. The DON also stated that it is important to administer medication in accordance with the physician's order to ensure proper absorption and patient safety. During a review of facility's policy and procedure (P&P), titled, Medication Administration, reviewed on 4/2025, the P&P indicated, Medications will be administered in a timely manner and as prescribed by the resident's attending physician.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Remove Resident 72's discontinued medication from the medication cart after the physician discontinued the order in one (1) of five (5) inspected medication carts (Medication Cart 2). 2. Label anˆover the counterˆ(OTC-medications available to consumers without a prescription)ˆmedication in one of three sampled medication storage rooms (Medication Storage Room C) These deficient practices had the potential to result in a medication error by allowing discontinued medication to remain in the cart and creating the risk of administering medication to the wrong resident, lost medication, or delayed treatment. ˆFindings: 1. Duringˆaˆreview of Residentˆ72'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted Resident 72 on [DATE] and was re-admitted on [DATE] with diagnoses including sepsis a serious infection that is already affecting their organs, chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure) and hypertension (high blood pressure). ˆ During a record review of Resident 72's History and Physical (H & P) dated [DATE], the H&Pˆindicatedˆ Resident 72 able to make simple medical decisions.ˆˆˆ During a review of Residentˆ72's Minimum Data Setˆ(MDS – a resident assessment tool), datedˆ[DATE],ˆthe MDS indicated the resident 72 cognitionˆ(relating to or involving the processes of thinking and reasoning)ˆwas severely impaired. During a review of Residentˆ72's Physician Order Report (POR), dated [DATE] to [DATE], the Physician Order Report indicated that the physician's order dated [DATE], for Cipro (Ciprofloxacin HCL) (a medication classified as an antibiotic used to treat infections) 500 milligrams(mg-unit of measurement) for urinary tract infection (UTI-infection caused bacteria entering the urinary system, commonly affecting the bladder) twice a day by mouth was discontinued on [DATE]. During an observation on [DATE] at 10:12 a.m., with Licensed Vocational Nurse (LVN) 7, of the Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs or Controlled Substances {CS}) drawer of Medication Cart 2 there were two medication bubble packs (medication cards that contain individual doses sealed in clear plastic bubbles with a foil backing), each with 5 doses of Cipro 500 mg. During a concurrent interview and record of Physician Order Record on [DATE] at 10:10 a.m. with LVN 7, LVN 7 stated there was an order for Cipro to be discontinued on [DATE]. LVN 7 stated that when a non-controlled medication order is discontinued, the standard practice is for nursing staff to place the discontinued medication in the medication room in the designated container, and if not used at all to return to the pharmacy. LVN 7 stated it is important to follow the facility policy of removing discontinued medications from the CM drawer to prevent medication error. LVN 7 stated the CM drawer was designed the storage of controlled medications, however, discontinued medications were also in the drawer. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and review record of the Physician Order Report on [DATE] at 10:23 a.m. with the Director of Nursing (DON), the DON stated based on their facility policy, when a non-controlled medication is discontinued the medication should be removed from the medication cart and placed in a secured medication room in the designated containers for disposition (facility's process for properly handling, removing, storing, returning, or destroying medications that are discontinued, expired, unused, or no longer required for the resident). The DON stated discounted medications should not be placed in the CM drawer to prevent medication error. 2. During a concurrent observation and interviewˆonˆ[DATE] at 10:48 am with Registered Nurse Supervisor (RN) 2 in Medication Storage Room C, a 36-count box of lozenges (medicated tablet designed to dissolve slowly in the mouth, providing temporary relief for sore throats, minor mouth irritations, and cough suppression) was stored without aˆlabel indicating a resident's name orˆexpirationˆdate. RN 2 stated the medication box did not have an expiration date or the resident's name indicated. During an interviewˆon [DATE] at 1:45 pm with the Pharmacist (Pharm), the Pharmˆstatedˆthe box of lozenges was not provided by the pharmacy and was an over-the-counter box of lozenge provided by a resident's family and the manufacturer did not provide an expiration date for the lozenges. During an interview on [DATE] at 1:50 pm with RN 2, RN 2 stated over-the-counter lozenges should have had the resident's name written on the box because without a name, licensed nurses would not know who the lozenges belonged to.ˆ During an interview on [DATE] at 2:00 pm with the Director of Nursing (DON),ˆthe DONˆstatedˆall medications in the medication storage rooms should be labeled. The DONˆfurther statedˆit is important toˆlabel resident's own medications and over the counter medications with the resident's name and room number to ensure accurate identification, prevent administration to the wrong resident, and avoid causing distress to the resident. During aˆreview of facility's policy and procedure (P&P) titled, Disposition of Controlled and Non-Controlled Medication, revised onˆ[DATE],ˆ the P&P indicatedˆwhen a non-controlled medication is discontinued or expired the medication shall be removed from the medication cart and placed in a secured medication room in the designated containers for disposition. The licensed nurse shall complete the Medication Disposition log. During a review of the facility's (P&P) titled, Medication Labeling, revised 08/ 2019, the P&P indicated, resident's own over-the-counter medications should be labeled withˆresident'sˆname and room number.ˆˆ

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appearance and flavor for lunch when chicken was served with some of the quills (the hollow central part of a feather) still in the skin for one of three residents (Resident 172) during dining observation. This failure had the potential to result in the resident not consuming meals or having poor food intake, which could lead to unintended weight loss. Findings: During a review of Residentˆ172'sˆFace Sheet,ˆtheˆFace Sheet indicated the facility admitted Residentˆ87ˆonˆ1/7/2026ˆwith diagnoses includingˆtype 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and gastro-esophageal reflux disease (a chronic condition where stomach acid frequently flows back up into the esophagus [food pipe]). During a review of Resident 172's History and Physical (H&P) dated 3/2/2026, the H&P indicated Resident 172 speaks in full sentences, was able to make her own needs known and able to make her own medical decisions. During a review of Residentˆ172's Minimum Data Set (MDS - an assessment and care screening tool) datedˆ2/13/2026,ˆthe MDS indicated the Resident 172 makes himself understood and understood others. The MDS furtherˆindicatedˆResidentˆ172ˆneeded supervision (helper provides verbal cues and/or touching assistance) for eating and oral hygiene and substantial assistance (helper does more than half the effort) with toileting, upper body dressing, lower body dressing, putting on/taking off shoes and personal hygiene. During an initial pool interviewˆon 3/9/2026 atˆ9:39ˆa.m. with Resident 172 in her room, Resident 172 was sitting up in her wheelchair eating a snack. Resident 172 stated she was a caterer in the past and food along with its presentation is important to her. Resident 172 stated she loves chicken on the bone, and the skin is her favorite part and the chicken the facility uses gets served with quills in the skin and she cannot eat it. Resident 172 stated the facility follows Kosher food laws (a set of Jewish [religion, culture and shared ancestry] dietary regulations to determine which foods are ok to eat) and although they state that they burn them off, there are still lots of [NAME] tips in the skin. During a concurrent observation and interview on 3/9/2026 at 12:11 p.m. in the fifth-floor bistro, Resident 172 was eating her lunch and asked the surveyor to come over. Resident 172 was eating the leg and thigh quarter of a chicken and stated there were quills in the skin. Resident 172 then pulled out several small quills, stated she was disgusted and removed all of the skin and set it aside. During a concurrent observation and interview on 3/9/2026 at 12:16 p.m. in the fifth-floor bistro with Certified Nursing Assistant (CNA 2), CNA 2 looked at Resident 172's chicken skin and stated she has seen quills in the chicken skin before and the kitchen is aware. CNA 2 stated Resident 172 enjoys her food less and does not finish her meal when there are quills left in her chicken. During an interview on 3/9/2026 at 1:02 p.m. with the Dietary Supervisor (DS), the DS stated the chicken source must be Kosher and often times the chicken on the bone with skin usually have some quills and the kitchen staff uses a torch to burn the quills. The DS stated he was made aware of the quills and is looking for a new source that is Kosher to purchase from so the chicken can be appetizing for all the residents. During a review of the facility's Policy and Procedure (P&P) titled Food Presentation, last reviewed 4/16/2025, the P&P indicated meals served to residents shall be presented in an attractive, appetizing and sanitary manner that promote adequate nutrition and resident satisfaction. During a review of the facility's P&P titled Meal Delivery Service, last reviewed 4/16/2025, the P&P indicated the meals shall be delivered to the residents in an attractive manner .and will meet the diets, consistency and personal preferences. During a review of the facility's P&P titled Standardized Recipes, last reviewed 4/16/2025, the P&P indicated the facility cooks shall follow recipes including the proper cutting, slicing and other preparations of ingredients.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs for one out of ten residents (Resident 3) observed while dining when Resident 3 was served a sandwich made with softened bread with the crusts left on while on a soft and bite-sized diet (foods that are soft, tender, moist, and easy to chew and swallow). This deficient practice had the potential to result in Resident 3 having difficulty with chewing and swallowing leading to a potential decrease in food intake and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of Resident 3's Face Sheet, the Face Sheet indicated the admitted the resident on 2/8/2024 with diagnoses including, but not limited to, chronic (long-term) atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 1/1/2026, the MDS indicated the resident had severe cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 3 was dependent (helper does all of the effort) on staff for toileting, bathing, and personal hygiene. The MDS indicated Resident 3 required substantial assistance (helper does more than half of the effort) with eating, oral hygiene, and dressing. During a review of Resident 3's Physician Order Report, the Physician Order Report indicated an order for a fortified (adding additional nutrients), soft and bite-sized diet, dated 6/4/2025. During a review of the facility's Menu and Diet Guidelines Manual titled, Summary of Diets, last reviewed April 2025, the manual indicated a soft and bite-sized diet follows the guidelines for International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) level 6 with a texture modification of soft foods that are easy to chew and swallow. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive), titled Spread Sheet Week 8 Winter 2026, dated 3/10/2026, the spreadsheet indicated residents on a soft and bite-sized diet would include a krab (imitation crab meat) salad roll and a soaked soft bun. During a concurrent observation and interview on 3/10/2026 at 12:19 p.m. with Certified Nursing Assistant (CNA) 3 and Resident 3, CNA 3 assisted Resident 3 to eat lunch. Observed the krab salad roll was served in bread which had the crusts on. CNA 3 stated the crust was still on the bread, but the bread was moistened so the resident can chew it more easily since she is on a soft and bite-sized diet. During an interview on 3/12/2026 at 10:34 a.m. with the Registered Dietician (RD), the RD stated the sandwich bread for a soft and bite-sized diet should be prepared following the IDDSI standards. The RD stated per the IDDSI standards the crusts on the bread should be removed then the bread should be soaked with liquid. The RD stated the IDDSI standards should be followed so that they can provide a safe diet texture to the residents and minimize the risk of choking. During a review of the IDDSI guidelines provided by the facility titled Level 6 Soft and Bite-Sized for Adults, dated January 2019, the guidelines indicated to avoid any crust which is formed during cooking or heating as it poses a choking risk.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately documentˆthe bloodˆglucose (BG-the main sugar found in the bloodstream) level,ˆamount of the insulin (medication that lowers the blood sugar)ˆunits, andˆinjection siteˆin MedicationˆAdministrationˆRecord (MAR) for one of two sampledˆresidentsˆ(Residentˆ94). This deficient practice had the potential to negatively impact on the delivery of treatment and services to Resident 94.Findings: Duringˆaˆreview of Residentˆ94'sˆFace Sheet, theˆFace Sheetˆindicated the facility originally admitted Residentˆ94ˆon 10/01/2023ˆand re-admitted resident on 1/12/2025, with diagnoses includingˆ diabetes mellitusˆ(DM-a chronic condition that affects the way the body processes blood sugar [glucose]),ˆwith diabetic polyneuropathy (nerve damage caused by diabetes that makes feet or hands feel numb, tingly, or painful),ˆmild cognitive impairment(mild thinking or memory problems)ˆof uncertain or unknowˆetiology (illness), andˆperipheral vascular disease(a condition where blood vessels outside heart and brain usually in legs become blocked or narrowed, causing poor blood flow).ˆ ˆˆ During a record review of Residentˆ94's History and Physical (H & P) datedˆ2/27/2026, the H&PˆindicatedˆResidentˆ94ˆdoes have the capacity to understand and make decisions on her own.ˆˆˆˆ During a review of Residentˆ94's MDS dated [DATE],ˆthe MDS indicated the residentˆ94's cognitionˆ(relating to or involving the processes of thinking and reasoning)ˆisˆintact.ˆˆˆ ˆ During a record review of Residentˆ94'sˆPhysician Order Report dated 3/1/2026 to 3/10/2026,ˆthe Physician Order indicatedˆan order dated 3/21/2025 for the following: -Novolog (fast acting insulin)ˆinsulinˆ8 units;ˆsubcutaneous (underˆskin)ˆforˆDMˆ; please rotate the site, hold Novolog ifˆblood sugarˆlessˆthanˆ100ˆmilligrams per deciliter((mg/di)ˆa unit of measurementˆto indicate how many milligrams of as glucoseˆare present in one deciliter (100ˆmL) of bloodˆ), onceˆa day, atˆ7:30ˆa.m.ˆˆ -ˆNovolog (fast acting insulin)ˆinsulinˆ8 units;ˆsubcutaneous (underˆskin)ˆforˆDMˆ; please rotate the site, hold Novolog ifˆblood sugarˆlessˆthanˆ100ˆmilligrams per deciliter((mg/di)ˆa unit of measurementˆto indicate how many milligrams of as glucoseˆare present in one deciliter (100ˆmL) of bloodˆ), onceˆa day, at 11:30 a.m. During a record review of Resident 94's Medication Administration Record (MAR)ˆdated 3/01/2026 to 3/10/2026, the MARˆindicatedˆthat for the order Novolog 8 units subcutaneously at 7:30 a.m., on 3/4/2026, 3/5/2026, 3/7/2026, and 3/9/2026., the injection site was documented as 0. ˆ During a record review of Resident 94's MAR dated 3/01/2026 to 3/10/2026, the MARˆindicated that the order for Novolog 8 units subcutaneously scheduled for 11:30 a.m., on 3/8/2026 at 11:30 a.m., the Units fieldˆindicatedˆ 115, and the BG result was documented as 0.ˆ During anˆinterview and record review onˆ3/10/2026ˆatˆ1:8ˆp.m.,ˆwith the DON,ˆResidentˆ94'sˆMAR dated 3/01/2026 to 3/10/2026 was reviewed.ˆ The DONˆstatedˆlicensed nurses should document the injection site in the MAR, such as Left upper arm. If the medication isˆnotˆadministered, they (licensed nurses) should enter N/A. TheˆDONˆstated that licensed nurses should not document 0 in that field because it can create confusion.ˆTheˆDONˆstatedˆthat the purpose of documenting the injection site is to ensure proper rotation of sites as required by the physician's order.ˆ The BG level in the MARˆindicatesˆthe resident's blood glucose reading, which is normally between 80 and 120 and documenting a BG of 0 is inaccurate, because aˆtrue BG of 0 would mean no glucose in the bloodstream, which wouldˆimmediatelyˆresult in loss of consciousness and death. Therefore, the current documentation is notˆaccurateˆand needs to be corrected.ˆ The DON further stated licensed nurses should document the number of insulin units they administer to theˆresidentsˆin the MAR. Based on the physician's Resident 94 should receive 8 units. The DONˆstatedˆthat staff incorrectly documented 115 units, which is not possible, becauseˆif Residentˆ94ˆreceived 115 units of insulin the resident would have experienced severe hypoglycemia andˆlikely goˆinto a hypoglycemic coma. The DON further stated that Residentˆ94ˆis healthy, which (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirms she did not receive 115 units. Therefore, the documentation is inaccurate and must be corrected.ˆ ˆ During a concurrent ˆinterview and record review onˆ3/12/2026ˆatˆ8:30ˆa.m.,ˆwith LicensedˆVocationalˆNurseˆ(LVN)ˆ4ˆResidentˆ94'sˆMAR datedˆ3/01/2026 to 3/10/2026ˆwas reviewed.ˆLVN4 stated she was assigned to Resident 94 on 3/8/2026, and she is the one who documented 115 units of insulin administered for a BG level of 0.ˆfor theˆ11:30 a.m. medication pass.ˆLVN 4ˆstated that she did not administer 115 units of insulin, and a BG level of 0 was notˆaccurate. SheˆstatedˆshE made a mistake and incorrectly documented theˆunits of insulin ˆand BG level in the MAR. LVN4ˆstatedˆshe documented the injection site as 0 for the dates 3/4/2026, 3/7/2026, and 3/9/2026 for the 7:30 a.m. medication pass, which is not correct because If the resident does not receive any insulin, the site should be documented as N/AˆnOt 0.ˆ ˆ During aˆreview of facility's P&P titled, Medication Administration, revised onˆ4/16/2025,ˆthe P&P indicatedˆdocumentation of MedicationˆAdministration,ˆthe individual administering theˆmedication must initial the residents/ patients MAR on theˆappropriate lineˆand date for the specific day before administering the next residents /ˆpatient'sˆmedication.ˆ Charting Medication Administration data:ˆ When medications are administered, the individual administering the medication must record in the residents/ˆpatient'sˆmedical record:ˆ The date and time the medication was administeredˆ The dosageˆ The route of administrationˆ The injection site (if applicable)ˆ Any complaints or symptoms for which the drug was administeredˆ Any results achieved and the time such results were observedˆ The signature and title of the person administering the drug.ˆ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555846	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joyce Eisenberg Keefer Medical Center D/P Snf	7150 Tampa Avenue 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 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the binding arbitration agreement (arbitration agreement, a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) was explained to residents' representatives in a form and manner that he or she understands for 1 (Resident 34) of 4 sampled residents. This had the potential for residents' rights to not be honored. Findings: During a review of Resident 34's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on [DATE] with diagnoses that included age-related physical debility (frailty, a syndrome characterized by progressive loss of muscle mass and reduced strength). During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 34 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 34 required setup or clean-up assistance (helper sets up or cleans us; resident completes activity) with eating. During a review of Resident 34's Arbitration Agreement, the document indicated Family Member of Resident 34 (FM34) signed the agreement on 2/06/2026. During a telephone interview with FM34 on 3/11/2026 at 10:18 a.m., she stated she was unaware of the document. FM10 stated she was not sure what an arbitration agreement was. FM10 stated she did not recall signing an arbitration agreement when she signed Resident 34's admission paperwork. During a concurrent record review and phone interview, the Admissions Director (ADIR) on 3/11/2026 at 1:31 p.m., the ADIR reviewed the facility's policy and procedure titled, Arbitration, last reviewed 4/16/2025 which indicated: The arbitration agreement: Must be separate from the admission agreement. Must be clearly labeled as Voluntary Arbitration Agreement. Must not be embedded within admission paperwork. Admissions staff shall verbally explain: Arbitration is voluntary. Signing is not required for admission or continued care. Resident has the right to consult an attorney. Resident may rescind within 30 days (recommended best practice). The ADIR stated, since approximately 2/26/2026, the facility has been emailing the arbitration agreement with a letter indicating this was a voluntary document to sign, separate from the admission paperwork. The ADIR stated she does not verbally explain the arbitration agreement, as per facility policy, to residents' families unless they ask questions. The ADIR stated by signing the letter this means residents' families understand what the arbitration agreement document is. During a concurrent interview and record review with the Administrator (ADM) on 3/12/2026 at 2:43 p.m., the ADM reviewed the facility's policy and procedure titled, Arbitration, last reviewed 4/16/2025. The ADM stated the facility recently has been emailing the arbitration agreement with a letter indicating this was a voluntary document to sign, separate from the admission paperwork. The ADM stated by signing the letter this means residents' families understand what the arbitration agreement document is. The ADM stated it is important for residents and residents' families to know what an arbitration agreement is, that they are signing an agreement and it is important for them to know what their signature means in a legal document and the implications of it including that it is voluntary, not a condition for admission, can rescind within 30 days, and can consult an attorney.^

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure patient care equipment was maintained in safe, comfortable operating condition for one of five sampled residents (Resident 78) by failing to ensure Resident 78's wheelchair was repaired in a timely manner when Resident 78's wheelchair push rim (also called hand rim-metal or plastic ring attached to the outside of a manual wheelchair's large wheels that allow users to self-propel [push/move]) was damaged. This deficient practice resulted in Resident 78's inability to comfortably propel her wheelchair and had the potential to negatively affect the provision of care and service provided to Resident 78. Findings: During a review of Resident 78's Face Sheet (FS), the FS indicated the facility originally admitted Resident 78 on 2/1/2025 and re-admitted on [DATE] with diagnoses including cellulitis (bacterial skin infection) of right upper limb (arms/legs), right elbow bursitis (painful inflammation or swelling of a bursa [small, fluid-filled sac that cushions bones, and muscles]) and abnormalities of gait (manner, style or pattern of walking) and mobility (ability to move, walk, or change in positions easily, freely, and independently). During review of Resident 78's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 2/17/2026, the MDS indicated Resident 78 has intact (undamaged/complete) cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS also indicated that Resident 78 has been using a wheelchair as a mobility device. During a concurrent observation and interview on 3/9/2026 at 10:21 a.m., with Resident 78 inside Resident 78's room, observed Resident 78's wheelchair push rims covered with black plastic tape around the entire rims. Resident 78 stated it is uncomfortable to use the wheelchair as she was unable to effectively propel herself due to pain when touching the push rims covered with plastic tape. Resident 78 further stated that a facility staff had notified her (Resident 78) they (facility) were awaiting insurance approval for replacement push rim covers. During a concurrent interview and record review on 3/11/2026 at 10:43 a.m., with the Director of Rehabilitation (DOR), Resident 78's Physical Therapy Evaluation and Plan of Treatment (PTEPT) dated 2/20/2026 and Discontinued General Order (DCGO), dated 2/20/2026 were reviewed. Resident 78's PTEPT indicated Resident 78 was evaluated for wheelchair maneuvering (moving) and Resident 78's requested for wheelchair push rim protectors due to damage. The PTEPT also indicated that central supply will provide and install new wheelchair push rim protectors. The DCGO indicated a physician order for central supply to provide resident with two wheelchair rim protectors and to install them. The DOR stated that the Central Supply Supervisor (CSS) had fixed Resident 78's wheelchair push rim by reinforcing the previous unlatched protector with a black plastic tape around and not installing a new protector. The DOR stated that the DOR was again made aware on the previous week that Resident 78 was not happy since it causes discomfort due to Resident 78's possible sensitivity to the tape. The DOR stated that she had notified the Director of Nursing (DON) regarding the issue and the DON had emailed the CSS to replace the whole wheelchair rim protector on 3/6/2026. During a concurrent interview and record review on 3/11/2026 at 12:21 p.m. with the CSS, a facility's document, titled, Request Forms was reviewed. The form indicated that on 2/20/2026, there was a request for two wheelchair push rim protectors to be installed for Resident 78. The form also indicated that the CSS had only added plastic tape around it. The CSS verified and stated that on 2/20/2026, he placed black plastic tape around the wheelchair rim protector due to the original rim was no longer latching properly. The CSS stated that a second request to fully replace the push rim protector was made on 3/6/2026 via the DON's email. The CSS stated that requests are expected to be fulfilled within 24 hours if the item is in stock and confirmed that the rim protectors were available and did not require (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordering. The CSS stated that he was only able to complete the replacement today, 3/11/2026 and acknowledged that it was important to replace the wheelchair push rim protectors promptly, as the condition of the wheelchair was causing discomfort to Resident 78. During an interview on 3/12/2026 at 9:20 a.m., with the DON, the DON stated that it is important that the facility promptly accommodate Resident 78's needs, including repairing the wheelchair, when the resident when propelling due to the plastic tape. During a review of facility's policy and procedure (P&P), titled, Medical Equipment, reviewed on 4/2025, the P&P indicated, Equipment that is broken, faulty or not working will contact maintenance immediately and central supply will make necessary repairs. The central supply will conduct performance and safety testing of all medical equipment before use. During a review of facility's P&P, titled, Accommodation of Needs, reviewed on 4/2025, the P&P indicated, Facility will create an individualized, home like environment, by making sure each resident has the right to resident and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other resident.