STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555862	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Scalabrini Special Care	10631 Vinedale Street Sun Valley, CA 91352

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of five (5) sampled residents (Resident 26) drug (medication) regimen was free from the use of unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications in accordance with the facility policy and procedure (P&P) by failing to provide a detailed clinical rationale for continuing Temazepam (a psychotropic medication used as a hypnotic [relating to, producing, or inducing sleep] for insomnia [inability to sleep or stay asleep]) at the original prescribed dose on 8/29/2024 for Resident 26. This deficient practice had the potential to place Resident 26 at risk for significant adverse consequences (unwanted, uncomfortable, or dangerous effects that a drug may have) from the use of unnecessary psychotropic medications, resulting in impairment or decline in the residents' mental, physical condition, functional, and psychosocial status.Findings: During a review of Resident 26's admission Record (a document containing demographic and diagnostic information,) dated 2/26/2026, the admission Record indicated the facility originally admitted Resident 26 to the facility on 3/20/2024 with diagnoses including depression (a health condition that causes constant feeling of sadness and loss of interest in activities that one would normally enjoy), insomnia (difficulty sleeping), psychosis (health condition affecting mind, emotions, behavior.) During a review of Resident 26's Minimum Data Set (MDS - a comprehensive resident assessment tool), dated 2/11/2026, the MDS indicated Resident 26 did not have symptoms of little interest or pleasure in doing things, felling down, depressed, or hopeless, trouble falling or staying asleep or sleeping too much. The MDS indicated Resident 26 diagnosis included depression, psychotic disorder and insomnia. Resident 26's MDS indicated Resident 26 received antipsychotics, antidepressants and hypnotic medications on a routine basis. During a review of Resident 26's Order Summary Report, dated 2/26/2026, the report indicated Resident 26 was prescribed Temazepam) 7.5 milligram ([mg] - a unit of measure of mass) capsule to give by mouth at bedtime for insomnia, starting 8/29/2024. During a review of Resident 26's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) initiated 6/21/2024, the Care Plan indicated Resident 26 was on sedative/hypnotic therapy Temazepam related to insomnia with a goal of sleeping 6 to 8 hours per night. During a review of Resident 26's Medication Administration Record ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record,) for November 2025, the MAR indicated to monitor hours of sleep at PM (evening) and HS (bedtime) every evening and night shift for Temazepam use. The monitoring documentation indicated Resident 26 slept 1.5 to 2 hours every evening and 7 to 8 hours every night. During a review of Resident 26's MAR for December 2025, the MAR indicated to monitor hours of sleep at PM and HS every evening and night shift for Temazepam use. The monitoring documentation indicated Resident 26 slept 0.5 to 2 hours every evening and 7 to 8 hours every night. During a review of Resident 26's MAR for January 2026, the MAR indicated to monitor hours of sleep at PM and HS every evening and night shift for Temazepam use. The monitoring documentation indicated Resident 26 slept 1.5 to 3 hours every evening and 7 to 8 (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hours every night. During a review of Resident 26's MAR for February 2026, the MAR indicated to monitor hours of sleep at PM and HS every evening and night shift for Temazepam use. The monitoring documentation indicated Resident 26 slept 2 hours every evening and 7 to 8 hours every night. During a review of the Medication Regimen Review (MRR) note by the Consultant Pharmacist (CP) for Resident 26 titled Note to Attending Physician/Prescriber and dated 1/21/2026, the note indicated Noted the resident has been on routine Temazepam 7.5 mg qhs (at bedtime) since 8/29/2024. Federal nursing regulations require that a gradual dose reduction ([GDR] - lowering dose, frequency or discontinuing medication]) be attempted at least quarterly for sedative/hypnotic medications used routinely and beyond the manufacturer's recommendations for duration of use, unless clinically contraindicated. Recommendation: Please re-evaluate the hypnotic order. If the current therapy is indicated for the resident, please document the risk vs. benefit. The document included a note written by a licensed vocational nurse (LVN) dated 2/13/2026 indicating Discussed hypnotic medication with Medical Doctor (MD) 1 over the phone. Per MD 1 continue with current dosing. Benefit outweighs risks. Needs to continue treatment to maintain quality of life and functional level of patient. MD 1 will sign this form on his next visit (2/2026). During a review of Resident 26's psychiatrist notes by MD 1, dated 1/29/2026, the note indicated that the resident feels fine, has no complaints, no behavior/problem/issue, progress is stable, and sleep is normal. The note did not indicate a plan for Temazepam use. During an interview and concurrent record review on 2/25/2026 at 2:38 p.m., with Director of Nursing (DON,) the DON reviewed Resident 26's MRR dated 1/21/2026, November 2025, December 2025, January 2026, February 2026 MARs, MDS dated [DATE], Care Plan (initiated 6/21/2024) and psychiatrist notes dated 1/29/2026. The DON stated that Resident 26 does not have documented behaviors of insomnia and slept at least 7 to 8 hours every night since November 2025. The DON stated the MRR dated 1/21/2026 indicated to continue Temazepam 7.5 mg dose by MD 1 and did not identify any clinical contraindications. The DON stated the psychiatrist note dated 1/29/2026 did not indicate clinical contraindications or treatment plan for Temazepam 7.5 mg qhs. The DON stated it was important to identify absence of behaviors and when individual resident goals are met and consider GDR for psychotropic medications to ensure residents receive treatment optimal for their condition while maintaining their highest level of well-being. The DON stated that the facility should have attempted a GDR for Temazepam 7.5 mg qhs or provided documentation in the MRR or psychiatrist notes indicating a clinical rationale for continuing Temazepam or what contraindications prevented the GDR of Temazepam for Resident 26. The DON stated the facility failed to attempt a GDR and/or indicate a clinical rationale for continuing Temazepam 7.5 mg qhs or what clinical contraindications prevented a GDR in the MRR note (dated 1/21/2026) or psychiatrist note (dated 1/29/2026). The DON stated as a result, Resident 26 was placed at risk of continuing unnecessary psychotropic medication that could result in adverse consequences and side effects, negatively impacting Resident 26's well-being. During a review of the facility's Policy and Procedures (P&P) titled Psychotherapeutic Medication Use, last reviewed 1/21/2026, the P&P indicated: A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics and antidepressants. The Facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications, including gradual dose reductions within the first year in which a resident is admitted on a psychotropic medication or after prescribing practitioner has initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters.After the first year, a GDR must be attempted annually, unless clinically contraindicated. During a review of the facility's P&P titled Psychotropic Documentation Guide, last reviewed 1/21/2026, the P&P indicated documentation needed in chart for Temazepam attempt a gradual dose reduction quarterly (approximately every 3 months) if used routinely and beyond the manufacturer's recommendations for duration of use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1.Reconcile (the process of comparing transactions and activity to supporting documentation) three (3) medication emergency kitS ([eKIT] - kit containing medications needed to be used during emergencies) containing ([CS] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as narcotics or Controlled Medication [CM]) for February 2026, in one (1) of one (1) inspected Medication Rooms (Medication Room.) 2. Account for one (1) dose of CM for Resident 21, 39 and 45 in one (1) of two (2) inspected medication carts (Medication Cart Green.) As a result, control and accountability of CSs did not follow state and federal regulations and facility policy and procedures. These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use,) and exposure of harmful medications to residents in the facility, that Resident 21, 30 and 45 could have accidental overdose (administration of more than the prescribed dose) to CM possibly leading to physical and psychosocial harm, hospitalization and death and the potential to result in Resident 21, 30 and 45's health and well-being to be negatively impacted. Findings: During an observation on 2/24/2026 at 11:50 a.m., with Licensed Vocational Nurse (LVN) 2, in Medication Cart Green, there was a discrepancy in the count between the Antibiotic or Controlled Drug Record accountability log and the amount of medication remaining in the medication cart or medication bubble pack (medication packaging system that contains individual doses of medication per bubble) for the following residents: 1.One (1) dose of clonazepam (a CM used for anxiety) one (1) milligram ([mg] - a unit of measure of mass) tablet was missing from the bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 21. The Antibiotic or Controlled Drug Record accountability log for clonazepam indicated the bubble pack should have contained a total of 25 clonazepam 1 mg tablets, after the last administration of clonazepam 1 mg tablet documented/signed off on 2/23/2026 at 8 a.m., however, the medication bubble pack contained 24 clonazepam 1 mg tablets and contained no other documentation of subsequent administrations. 2. One (1) dose of clonazepam 0.5 mg tablet was missing from the bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 45. The Antibiotic or Controlled Drug Record accountability log for clonazepam indicated the bubble pack should have contained a total of 54 clonazepam 0.5 mg tablets, after the last administration of clonazepam 0.5 mg tablet documented/signed off on 2/23/2026 at 9 p.m., however, the medication bubble pack contained 53 clonazepam 0.5 mg tablets and contained no other documentation of subsequent administrations. 3. One (1) dose of tramadol (a CM used for pain) 50 mg tablet was missing from the bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record accountability log for Resident 39. The Antibiotic or Controlled Drug Record accountability log for tramadol indicated the bubble pack should have contained a total of 12 tramadol 50 mg tablets, after the last administration of tramadol 50 mg tablet documented/signed off on 2/23/2026 at 9 p.m., however, the medication bubble pack contained 11 tramadol 50 mg tablets and contained no other documentation of subsequent administrations. During a concurrent interview with LVN 2, LVN 2 stated LVN 2 administered one (1) clonazepam 1 mg tablet to Resident 21 at 8:27 a.m., one (1) clonazepam 0.5 mg tablet to Resident 45 at 9 a.m. and one (1) tramadol 50 mg tablet to Resident 39 at 9:13 a.m. that morning (2/24/2026) and forgot to sign the Antibiotic or Controlled Drug Record accountability logs. LVN 2 stated LVN 2 failed to follow the facility's policy of signing each CM dose on the Antibiotic or Controlled Drug Record accountability log after preparing the dose for the resident. LVN 2 stated LVN 2 understood it was important to sign each dose once administered to ensure accountability, prevention of CM diversion, and accidental exposures of harmful substances to residents. LVN 2 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated if documentation was not accurate then it can lead to medication error, which could result in an overdose and potentially lead to stoppage of breathing, hospitalization and possibly death for Resident 21, 39 and 45. During an observation and concurrent interview on 2/24/2026 at 12:15 P.M., with LVN 1 and the Director of Nursing (DON), in Medication Room, there was: 1.One (1) medication eKIT stored in the refrigerator and labeled REF466, containing CSs without an accountability log for the reconciliation of CS inventory at every shift change for February 2026.ˆ 2. Two (2) medication eKIT stored in the cabinet at room temperature and labeled 351 and 501, containing CSs without an accountability log for the reconciliation of CS inventory at every shift change for February 2026.ˆ During a concurrent interview, LVN 1 stated that all CSs, including medication eKITs containing CSs should be reconciled at every shift. LVN 1 stated the eKIT labeled REF466, 351 and 501, containing CSs in Medication Room were not reconciled at every shift in February 2026, and it was important to account for all CSs to ensure accountability and prevent CS diversion. The DON acknowledged the eKITs labeled REF466, 351 and 501 did not have accountability logs and were not reconciled at every shift in February 2026. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKits containing CSs. During an interview on 2/25/2026 at 2 p.m., with the DON, the DON stated that LVN 2 failed to follow facility policy of documenting the preparation of CM immediately on the Antibiotic or Controlled Drug Record accountability log for Resident 21, 39 and 45. The DON stated not documenting the Antibiotic or Controlled Drug Record timely can lead to accountability failures, CM diversion, inaccurate clinical records, and accidental use and overdose of harmful substances for residents. During a review of Resident 21's admission Record (a document containing demographic and diagnostic information,) dated 2/24/2026, the admission Record indicated Resident 21 was originally admitted to the facility on [DATE] with diagnoses including anxiety. During a review of Resident 21's Medication Administration Record ([MAR - record of medications administered to a resident) for February 2026, the MAR indicated Resident 21 was prescribed clonazepam one (1) mg orally once a day related to anxiety, to be given at 9 a.m. During a review of Resident 39's admission Record dated 2/24/2026, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] with diagnoses including osteoarthritis (joint disease resulting in bones rubbing together causing pain, stiffness, swelling, and reduced function in jointsˆlike knees, hips, hands.) During a review of Resident 39's MAR for February 2026, the MAR indicated Resident 39 was prescribed tramadol 50 mg orally two (2) times a day for moderate pain (pain rating of 4-6 on a 0-10 pain scale), to be given at 9 a.m. and 9 p.m. During a review of Resident 45's admission Record dated 2/24/2026, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] with diagnoses including anxiety. During a review of Resident 45's MAR for February 2026, the MAR indicated Resident 45 was prescribed clonazepam 0.5 mg orally twice a day for anxiety, to be given at 9 a.m. and 9 p.m. During a review of the Policy and Procedures (P&P) titled Controlled Medications, last reviewed 1/21/2026, the P&P indicated: C. When a CM is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the MAR: 1) date and time of administration 2) amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. During a review of the P&P, titled Controlled Medication Storage, last reviewed 1/21/2026, the P&P indicated: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substance are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. a. The DON and the consultant pharmacist maintain facility's compliance with federal and state laws and regulations in the handling of controlled medications. d. At each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Six (6) medication errors out of 31 total opportunities contributed to an overall medication error rate of 19.35% affecting three (3) of five (5) residents observed for medication administration (Resident 7, 39 and 47.) The medication errors were as follows: 1.Resident 7 did not receive folic acid (a supplement used for osteoarthritis [a joint disease where the cushions at the ends of bones breaks down causing pain, stiffness, and reduced function]) as ordered by Resident 7's physician. 2. Resident 39 did not receive multivitamins with minerals (a vitamin supplement,) and loratadine (a medication used for itching,) as ordered by Resident 47's physician. 3. Resident 47 did not receive multivitamins with minerals, cyanocobalamin (a medication used for nerve damage), and Systane (a medication used for dry eyes,) as ordered by Resident 47's physician. These failures had the potential to result in Resident 7, 39 and 47 to experience medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have,) and health complications such as vitamin deficiencies, worsening dry eyes and itch resulting in Resident 7's, 39's and 47's health and well-being to be negatively impacted. Findings: During an observation on 2/24/2026 at 8:50 a.m., in Medication Cart Green, Licensed Vocational Nurse (LVN) 2 was observed administering duloxetine DR (a medication used for neuropathic [nerve] pain) 30 milligram ([mg] - a measure of unit of mass) capsule, escitalopram (a medication used for depression) 5 mg tablet, metoprolol (a medication used for hypertension [high blood pressure]) 25 mg tablet, clopidogrel (a medication used for heart disease) 75 mg tablet, ocular (for the eye) vitamin tablet orally to Resident 47. Resident 47 was observed swallowing the medications with glass of water. LVN 2 was not observed administering multivitamin with minerals, cyanocobalamin and Systane to Resident 47. During an observation on 2/24/2026 at 9 a.m., in Medication Cart Green, LVN 2 was observed administering sertraline (a medication used depression) 50 mg tablet, quetiapine (a medication used for hallucinations [a false perception of reality]) 25 mg tablet, senakot (a medication used constipation) 8.6 mg tablet, crushed and mixed with applesauce, orally to Resident 7. LVN 2 was not observed administering folic acid to Resident 7. During an observation on 2/24/2026 at 9:09 a.m., in Medication Cart Green, LVN 2 was observed administering metformin (a medication used for high blood sugar levels) 500 mg tablet, fluvoxamine (a medication used for depression [mood disorderˆhaving intense sadness and a loss of interest in activities]) 25 mg tablet, myrbetriq ER (a medication used for overactive bladder [a condition that causes uncontrollable and frequent urge to urinate]) 25 mg tablet, calcium citrate with vitamin D3 (a supplement) tablet, tramadol (a medication used for pain) 50 mg tablet orally to Resident 39. Resident 39 was observed swallowing the medications with glass of water. LVN 2 was not observed administering multivitamin with minerals and loratadine to Resident 39. During an interview on 2/24/2026 at 11:30 a.m., with LVN 2, LVN 2 stated LVN 2 administered several medications orally to Resident 47, and failed to prepare and administer multivitamin with minerals, cyanocobalamin and Systane that day (2/24/2026) at 8:50 a.m. to Resident 47. LVN 2 acknowledged the Resident 47's physician's order specified to administer multivitamin with minerals, cyanocobalamin and Systane at 9 a.m. LVN 2 stated LVN 2 administered several medications orally to Resident 7 and failed to prepare and administer folic acid that day (2/24/2026) at 9 a.m. to Resident 7. LVN 2 acknowledged the Resident 7's physician's order specified to administer folic acid at 9 a.m. LVN 2 stated LVN 2 administered several medications orally to Resident 39 and failed to prepare and administer multivitamin with minerals and loratadine that day (2/24/2026) at 9:09 a.m. to Resident 39. LVN 2 acknowledged the Resident 39's physician's order specified to administer multivitamin with minerals and loratadine at 9 a.m. LVN 2 stated per facility policy, there was a 60-minute window before and after the scheduled time for medication administration, and that Residents 7, 39 and 47 did not receive their medications during that window. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated that LVN 2 failed to follow five (5) rights of medication administration and failed to administer medications as prescribed to Resident 7, 39 and 47 that day at 9 a.m. LVN 2 stated these were considered medication errors. During an interview on 2/25/2026 at 2 p.m., with the Director of Nursing (DON,) the DON stated that LVN 2 failed to administer folic acid to Resident 7, multivitamin with mineral and loratadine to Resident 39 and multivitamins with minerals, cyanocobalamin and Systane to Resident 47 on 2/24/2026 during morning medication administration, increasing the risk of vitamin deficiencies, exacerbating (making worse) dry eyes, and allergies for the residents. The DON stated per facility policy, medications should be administered within a 60-minute window from the time scheduled by the physician. The DON stated that LVN 2 failed to follow the 10 rights of medication administration and facility medication administration guidelines, resulting in medication errors for Residents 7, 39 and 47. During a review of Resident 7's admission Record (a document containing demographic and diagnostic information,) dated 2/24/2026 the admission Record indicated Resident 7 was originally admitted to the facility on [DATE] with diagnosis including arthritis (a disease that causes inflammation, pain, stiffness, and swelling in joints) and osteoarthritis. During a review of Resident 7's Order Summary Report (a report listing the physician order for the resident,) dated 2/24/2026, the report indicated Resident 7 was prescribed: -Folic acid 1 mg, to give orally once a day for vitamin supplement, starting 12/31/2025. During a review of Resident 7's ([MAR] - a document of the medications administered to a resident that is part of the resident's permanent medical record], for February 2026, the MAR indicated Resident 7 was prescribed: -Folic acid 1 mg tablet orally once a day for vitamin supplement, to be given at 9 a.m. During a review of Resident 39's admission Record, dated 2/24/2026, the admission Record indicated Resident 39 was originally admitted to the facility on [DATE] with diagnosis including osteoporosis and bone density disorder. During a review of Resident 39's Order Summary Report dated 2/24/2026, the report indicated Resident 39 was prescribed: 1.Multivitamin with minerals one (1) tablet orally once a day for supplement, starting 3/18/2025 2. Loratadine 10 mg tablet orally once a day for itchiness, starting 4/23/2025 During a review of Resident 39's MAR for February 2026, the MAR indicated Resident 39 was prescribed: 1.Multivitamin with minerals one (1) tablet orally once a day for supplement, to be given at 9 a.m. 2. Loratadine 10 mg one (1) tablet orally once a day for itchiness, to be given at 9 a.m. During a review of Resident 47's admission Record dated 2/24/2026 the admission Record indicated Resident 47 was originally admitted to the facility on [DATE] with diagnosis including osteoarthritis, macular degeneration (eye disease,) polyneuropathy (nerve damage.) During a review of Resident 47's Order Summary Report dated 2/24/2026, the report indicated Resident 47 was prescribed: 1.Multivitamin with minerals one (1) tablet orally once a day for supplement, starting 2/17/2026 2. Cyanocobalamin 1000 microgram ([mcg] a unit of measure of mass) tablet orally once a day for supplement, starting 1/29/2026. 3. Systane 0.5 inch in the left eye twice a day for ectropion (a condition caused by aging that causes dry eyes,) starting 2/23/2024. During a review of Resident 47's MAR for February 2026, the MAR indicated Resident 47 was prescribed: 1.Multivitamin with minerals one (1) tablet orally once a day for supplement, to be given at 9 a.m. 2. Cyanocobalamin 1000 mcg one (1) tablet orally once a day for supplement, to be given at 9 a.m. 3. Systane 0.5 inch in the left eye twice a day for ectropion, to be given at 9 a.m. and 6 p.m. During a review of the facility's Policy and Procedures (P&P) titled Medication Administration-General Guidelines, last reviewed 1/21/2026, the P&P indicated that Medications are administered as prescribed . Procedures 2.Medications are administered in accordance with written orders of the attending physician. 10.Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after). During a review of the facility's P&P titled Incident Reporting, last reviewed 1/21/2026, the P&P indicated: Medication/Treatment Variances: The following incidents/concerns may be recorded on an appropriate Incident Report form: missed medication or treatment orders. During a review of the facility's P&P, titled Medication Pass Tope, last reviewed 1/21/2026, the P&P indicated: Acceptable medication pass time is one hour before to one hour after the scheduled time for most medications (due at 9 a.m. give between 8 a.m. and 10 a.m. Remember ten rights of medication pass right time.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and distribution when: 1. Pasta was stored in a container with a lid that was not tightly sealed. 2. One tomato and one onion were cut in half and stored in the refrigerator in plastic wrap with no date. These failures had the potential to result in harmful bacterial growth, cross contamination (transfer of harmful bacteria or allergens from one place to another), and foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 53 residents who received food from the kitchen out of 56 total residents. 3. For Residents 5 and 30, meal trays were transported down a hallway to residents eating in their rooms with some food items left uncovered. This failure had the potential to result in cross contamination and foodborne illness in two out of three residents observed while dining. Findings: 1. During a concurrent observation and interview on 2/23/2026 at 8:01 a.m. with the Director of Dietary Services (DODS) in the dry storage area, a container of pasta was stored with the lid placed on top at an angle leaving the pasta exposed to air. The DODS stated the lid should be closed so nothing touches the pasta and no pests get inside the container. During a review of the facility's policy and procedure (P&P), titled, Food Storage, last reviewed 1/21/2026, the P&P indicated all food will be properly stored and to refer to the food storage charts for additional guidelines. The food storage chart indicated once pasta is opened it should be stored in an airtight container. 2. During a concurrent observation and interview on 2/23/2026 at 8:05 a.m. with the DODS in the walk-in refrigerator, one half of an onion and one half of a tomato were stored in plastic wrap with no date. The DODS said they should be labeled with a date the items were cut into so dietary staff will know when they were cut and when they can safely use the food by. During a review of the facility's P&P titled, Food Storage, last reviewed 1/21/2026, the P&P indicated all open food items will have an open date and to refer to the food storage charts for additional guidelines. The food storage chart indicated ripe tomatoes should be refrigerated for 1-2 days. 3. During a review of Resident 5's admission Record, the admission Record indicated the facility admitted the resident on 4/3/2025 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 5's Minimum Data Set (MDS - a resident assessment tool), dated 12/2/2025, the MDS indicated Resident 5 is rarely or never understood and has short and long-term memory problems. The MDS indicated Resident 5 was dependent (helper does all of the effort) on facility staff to complete all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 5's Order Summary Report, the Order Summary Report indicated an order for a regular diet (a balanced, nutritious eating plan designed for individuals not requiring specific dietary modifications) with pureed texture (smooth, pudding-like, and lump-free foods designed for individuals with chewing or swallowing difficulties), dated 12/23/2025. During a review of Resident 30's admission Record, the admission Record indicated the facility admitted the resident on 11/24/2018 with diagnoses including, but not limited to, Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and low back pain. During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 had severe cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 30 was dependent on staff for toileting, bathing, lower body dressing, and personal hygiene. The MDS indicated Resident 30 required substantial assistance (helper does more than half of the effort) with oral hygiene and upper body dressing. The MDS indicated Resident 30 required moderate assistance (helper does less than half of the effort) with eating. During a review of Resident 30's Order Summary Report, the Order Summary Report indicated an order for a regular diet with regular texture, dated (continued on next page)

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	555862	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Scalabrini Special Care	10631 Vinedale Street Sun Valley, CA 91352

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/23/2025. During an observation on 2/23/2026 at 12:08 p.m., a tray containing a dish with pureed green food with no cover was on an open cart outside in the hallway outside of Resident 5's room. The tray was labeled with Resident 5's information. During an observation on 2/23/2026 at 12:12 p.m., Resident 5's tray was now in front of the resident at her bedside including the uncovered dish with green pureed food. During an observation on 2/25/2026 at 12:21 p.m., observed a tray labeled with Resident 30's information containing uncovered dishes with peaches and salad with no cover was pushed on an open cart from the dining room through the hallway to Resident 30's room and placed on a table at her bedside. During an interview on 2/26/2026 at 10:44 a.m. with the Director of Dietary Services (DODS), the DODS stated food should be covered if it is in the hallway. The DODS stated if it is not covered it risks cross contamination or insects getting into the food. During an interview on 2/26/2026 at 11:50 a.m. with the Infection Preventionist (IP), the IP stated food should be covered while transporting it to residents. The IP stated if it is not covered it can be exposed to anything that is in the hallway and there is a risk of infection to the residents. During a review of the facility's P&P, titled Safe Transport of Food from Kitchen to Dining Rooms, last reviewed 1/21/2026, the P&P indicated to protect food during movement all trays and pans should be covered.

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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. Based onˆobservation,ˆinterviewsˆand record review, the facilityˆfailed toˆmaintainˆinfection control measuresˆwhen: a. Certified Nursing Assistant (CNA 1) was not wearing a face mask (personal protective equipmentˆthat serves as a mechanical barrierˆto interfere with air flowˆfromˆthe nose andˆmouth)ˆwhile in the dining room assisting residents. b. TheˆDirector of Dietary Servicesˆ(DODS) was not wearing a maskˆ(personal protective equipmentˆthat serves as a mechanical barrierˆto interfere with air flowˆfromˆthe nose andˆmouth)ˆwhile in the dining room.ˆ This deficient practiceˆincreased the potential of spreading respiratory illnesses to the residents in the facility.ˆ Findings: a. During aˆconcurrentˆobservation an interviewˆon 2/23/2026ˆatˆ1:10ˆp.m. withˆCNA 1 in the dining room,ˆCNA 1ˆwasˆobservedˆnot wearing a mask and chewing food as he entered the dining room. Observed CNA 1 was assisting residents during the lunch service and transporting residents from the dining room to their rooms. CNA 1 stated he was aware that he was supposed to wear a mask and stated he forgot to put it back on. During a concurrent observation and interview onˆ2/23/2026 at 1:12 p.m. in the dining room with the Infection Preventionist (IP), the IPˆwalked in and stated to CNA 1, put on a mask, you have to wear a mask around the residents. The IP statedˆthat all staff need to wear a mask all of the time, especially around residents. The IPˆstatedˆstaff must wear masks anywhereˆresidents live or receive careˆsuch asˆthe dining room to keep residents safe from respiratory illnessesˆ(germs that can cause illnessesˆwhichˆaffectˆtheˆlungs and airways).ˆˆ During a review of the facility's policy and procedure (P&P) titled, COVID-19 Surveillance Plan,ˆlast reviewed 1/21/2026,ˆtheˆP&PˆindicatedˆAll staff to wear surgical mask during working hours.ˆ b. During aˆconcurrentˆobservation and interviewˆonˆ2/25/2026ˆatˆ11:53ˆa.m. withˆthe DODS in the dining room,ˆthe DODSˆwasˆobservedˆnot wearing a mask.ˆResidents were seated waiting for their lunch traysˆwhile the DODS was present. The DODSˆstatedˆheˆhad been vaccinatedˆ(treated withˆmedicationsˆthatˆproduce immunity to a particular infectious disease)ˆso he did not need to wear a mask.ˆˆ During an interview onˆ2/25/2026 at 2:54 p.m. with the Infection Preventionist (IP), the IPˆstatedˆthat all staff members need to mask 100% of the time regardless of their vaccine status.ˆThe IPˆstatedˆthe areasˆinˆthe facilityˆstaff need to mask include anywhereˆresidents live or receive careˆsuch asˆthe dining room. The IP stated staff needed to wear masks to keep residents safe from respiratory virusesˆ(germs that can cause illnessesˆwhichˆaffectˆtheˆlungs and airways).ˆˆ During a review of the facility's policy and procedure (P&P) titled, COVID-19 Surveillance Plan,ˆlast reviewed 1/21/2026,ˆtheˆP&P indicatedˆAll staff to wear surgical mask during working hours.ˆ

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that resident's Care Plan (a document outlining a detailed approach to care customized to an individual resident's need) included objective measurable goals for monitoring insomnia (a condition characterized by inability to fall or stay asleep) for one (1) of five (5) sampled residents (Residents 12) reviewed for unnecessary (any medication in excessive dose, excessive duration, without adequate monitoring) medications. As a result, Resident 12 did not have an identified goal for minimum number of hours spent sleeping, to monitor the effectiveness of Resident 12's medication therapy related to insomnia. This deficient practice had the potential to cause Resident 12 to receive suboptimal (less than the highest standard or quality) care, not know how effective the current medication therapy for her insomnia is, possibly leading to medication overdose (giving doses beyond the necessary amount) or underdose (not giving enough of a dose), resulting in excessive sedation or tiredness, and inability to function and participate in normal daily activities. Findings: During a review of Resident 12's admission Record (a document containing demographic and diagnostic information,) dated 2/26/2026, the admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and re-admitted on [DATE] with a diagnoses including depression (a health condition that causes constant feeling of sadness and loss of interest in activities that one would normally enjoy, including insomnia) and psychotic disorder (health condition affecting mind, emotions, behavior.) During a review of Resident 12's Minimum Data Set (MDS- a comprehensive resident assessment tool), dated 12/1/2025, the MDS indicated the resident's cognition (how a person thinks and processes information) was severely impaired. The MDS indicated the resident does not have symptoms of trouble falling or staying asleep or sleeping too much. The MDS also indicated Resident 12 received antipsychotics and antidepressant medications on a routine basis. During a review of Resident 12's Order Summary (a document containing orders prescribed by the doctor), dated 2/26/2026, the report indicated Resident 12 was prescribed trazodone (a medication used to treat insomnia) 50 milligram ([mg]- a unit of measure of mass) tablet orally at bedtime manifested by insomnia related to depressive disorder at 9 p.m., starting 4/21/2025. During a review of Resident 12's Care Plan for depression manifested by insomnia, dated 2/20/2026, the Care Plan indicated to monitor and document hours of sleep on evening and nigh shift, and to monitor side effects and effectiveness of trazodone. The Care Plan did not indicate a measurable target goal for hours of sleep. During a review of Resident 12's Medication Administration Record ([MAR] - a record of mediations administered to residents), dated February 2026, the MAR indicated Resident 12 was monitored for hours of sleep every evening and night, and slept up to 3 hours in the evening and 6 to 8 hours at night daily. During a concurrent interview and record review, on 2/25/2026 at 12:20 p.m., with Minimum Data Set Coordinator (MDSC,) the MDSC reviewed Resident 12's Care Plan dated 2/20/2026. The MDSC stated that care plans should include objective measurable goals for residents' areas of concern. The MDSC stated that Resident 12's Care Plan did not indicate a measurable goal of minimum or maximum number of hours of sleep for Resident 12 with the use of trazodone. The MDSC stated that residents on these types of medications should have their sleep monitored to know the effectiveness of the medication. The MDSC stated that monitoring for insomnia was individualized for each resident, because each resident may require different amount of sleep for their condition and/or preference. The MDSC stated the Care Plan should include a goal for Resident 12's hours of sleep.ˆThe MDSC stated without an identified goal for hours of sleep, it was unknown what outcome was acceptable for Resident 12's insomnia. The MDSC stated the facility failed to have an individualized measurable goal for hours of sleep with the use of trazodone for insomnia in the Care Plan for Resident 12. During an interview on 2/26/2026 at 1:48 p.m., with the Director of Nursing (DON,) the DON stated a measurable goal for hours of sleep was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed to evaluate the effectiveness of trazodone for insomnia for Resident 12. The DON stated the number of hours slept was being monitored, but the facility failed to care plan an individualized goal for the minimum or maximum number of hours of sleep needed for Resident 12. The DON stated that nursing staff usually communicate the number of hours residents slept to the physician. However, because the Care Plan lacked a goal for hours of sleep, the staff cannot determine if Resident 12's current number of hours were of concern, and unclear when to trigger communication to the physician for reassessment of effectiveness of trazadone or what was an acceptable outcome for Resident 12's insomnia. During a review of review facility's Policy and Procedures (P&P,) titled Care Plan Policy Comprehensive, last reviewed 1/21/2026, the P&P indicated, Our facility's Care Planning/interdisciplinary Team, in coordination with the resident, his/her family or representative (sponsor), develops and maintains a comprehensive care plan for each resident that identifies the highest level of functioning the resident may be expected to attain. Each resident's comprehensive care plan is designed to: reflect treatment goals, timetables and objectives in measurable outcomes. Care plans are reviewed by the Care Planning Team at least quarterly.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview and record review, the facility failed to ensure that a resident who was diagnosed with dementia (a progressive state of decline in mental abilities) received the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being for one of six residents (Resident 23) reviewed under the dementia care by failing to develop an individualized care plan with interventions addressing supervision to support Resident 23's dementia care needs. This failure had the potential to affect Resident 23's safety and well-being. Findings During a review of Resident 23's admission Record, the admission Record indicated the facility admitted Resident 23 on 10/20/2020 with diagnoses including dementia and macular degeneration (age related eye condition that causes blurred vision or reduced vision) During a review of Resident 23`s History and Physical (H&P) dated 2/22/2025, the H&P indicated Resident 23 did not have the capacity to understand and make decisions. During a review of Resident 23`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 12/22/2025, the MDS indicated Resident 23 usually understood others and usually made herself understood and had moderately impaired (limited vision; not able to see newspaper headlines, but can identify objects) vision and was unable to recall (remember) three words when asked to recall them. The MDS indicated Resident 23 was dependent (helper does all the effort) on facility staff for toileting, bathing, hygiene and putting on/taking off shoes. During a review of Resident 23's Impaired Cognitive (knowledge and understanding) Function/Impaired Thought Process related to Dementia Care Plan (CP), the CP indicated Resident 23 had episodes of confusion and disorientation and has short term memory loss. The CP did not include interventions to addressing the need for supervision. During an observation on 2/23/2026 at 1:04 p.m. in the dining/activity room, the door was closed and Resident 23 was observed seated in the wheelchair at the far end of the large dining room, facing the wall, eating lunch alone and without supervision. At 1:08 p.m. The Infection Preventionist (IP) opened the door to the dining room and walked over and stood near Resident 23. At 1:10 p.m. Certified Nursing Assistant (CNA 1) walked in from another back door into the dining room. During an interview on 2/23/2026 at 1:10 p.m. in the dining room with CNA 1, CNA 1 stated Resident 23 should never be left alone, and that he (CNA 1) had only left for a few minutes to get something to eat. CNA 1 stated Resident 23 takes a very long time to eat and is usually the last resident in the dining room; however, the resident should not have been left alone due to confusion. During an interview on 2/23/2026 at 1:16 p.m. in the dining room with the IP, the IP stated Resident 23 has dementia, and should not be left alone in the dining room. The IP further stated that the CNA should not have left Resident 23 unattended, especially because the resident is facing the wall and his face was not visible in the event he was choking. During a concurrent interview and record review of Resident 23's Dementia CP with the Director of Nursing (DON), the DON reviewed the dementia CP. The DON stated the CP was not individualized to include an intervention addressing supervision. The DON stated Resident 23 gets confused and should not be left alone in the dining room while eating. During a review of the facility's Policy and Procedure (P&P) titled Care of Resident's with Dementia, last reviewed 1/21/2026, the P&P indicated the facility emphasizes individualized care for residents with dementia and that care must be individualized based on comprehensive assessment and documented in the CP. The P&P indicated the facility shall maintain fall reduction program, safe environment for cognitively impaired residents and supervision levels appropriate to risk.