STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555885	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherman Oaks Hospital Snf Dp	4929 Van Nuys Blvd Sherman Oaks, CA 91403

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43988 Based on observation, interview, and record review the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for two (2) of (2) sampled residents (Residents 4 and 2) reviewed under the Environment task. This deficient practice had the potential to result in the delay of care and services and possible injury to residents when they are unable to call for assistance. Findings: a. During a review of Resident 4's Admission/Registration form, the Admission/Registration form indicated the facility originally admitted the resident on 8/24/2018 and readmitted in the facility on 12/20/2024 During a review of Resident 4's History and Physical (H&P), dated 1/2/2025, the H&P indicated Resident 4 had diagnoses of chronic respiratory failure (a long-term condition in which your lungs have a hard time loading your blood with oxygen and can leave you with low oxygen), ventilator (a medical device to help support or replace breathing) dependent, and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) disorder. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's SA Fall Risk Assessments (a simple method of assessing a resident's likelihood of falling), dated 8/15/2024, 11/8/2024, and 2/6/2025, the SA Fall Risk Assessments indicated the resident is a high risk for falls. During a review of Resident 4's care plan (CP) on risk for falls, initiated on 1/2/2025, the CP indicated to place call light within reach at all times as one of the interventions to prevent falls or injury. (continued on next page)

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 4/11/2025, at 8:07 p.m., inside Resident 4's room, with Certified Nursing Assistant (CNA) 1, CNA 1 confirmed and stated Resident 4's call light was hanging on the wall at the head of the bed. CNA 1 stated staff should place the call lights within resident's reach prior to leaving the room. CNA 1 stated she just finished turning and repositioning Resident 4, and she forgot to place the call light within the resident's reach. CNA 1 stated she should have ensured that Resident 4's call light was placed within the resident's reach prior to leaving the room so the resident would be able to call for assistance. During a concurrent observation and interview, on 4/11/2024, at 8:07 p.m., inside Resident 4's room, with Licensed Vocational Nurse (LVN) 8, LVN 8 confirmed and stated Resident 4's call light was hanging on the wall at the head of the bed. LVN 8 stated staff should make sure the call lights are placed within resident's reach prior to leaving the room. LVN 8 stated CNA 1 should have ensured that Resident 4's call light was placed within reach prior to leaving the room so the resident would be able to call for assistance when needed. During an interview, on 4/11/2025, 8:30 p.m., with Registered Nurse (RN) 1, RN 1 stated staff have to make sure that all call lights are within resident's reach after providing or turning and repositioning and prior to leaving the room. RN 1 stated CNA 1 should have placed Resident 4's call light within reach after turning and repositioning and prior to leaving the room to make sure that Resident 4 would be able to call for assistance and prevent delay in meeting the resident's needs. During a review of the facility's policy and procedure (P&P) titled, Call System, last reviewed on 2/2025, the P&P indicated a purpose to provide a mechanism for residents to communicate to staff a need for assistance. The P&P further indicated to make sure call cords are always placed within the resident's reach. 49947 b. During a review of Resident 2's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 2 on 4/4/2025. During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 was rarely/never understood and never/rarely made decisions. The MDS further indicated Resident 2 was dependent on facility staff for activities such as eating, hygiene and dressing. During a review of Resident 2's Nutritional Screening, dated 4/11/2025, the Nutritional Screening indicated Resident 2's diagnoses included chronic respiratory failure (a long-term condition where the lungs are unable to adequately exchange oxygen [gas used for breathing]and carbon dioxide [gas given off from breathing]), chronic encephalopathy (group of conditions that cause brain dysfunction), tracheostomy, cerebral palsy (a group of disorders that affect movement and posture due to damage to the developing brain before, during, or shortly after birth), and seizure disorder (a sudden, temporary disturbance of the brain's electrical activity). During a review of Resident 2's CP titled, Need Assist with ADLs, dated 4/4/2025, the CP indicated an intervention to keep call light with reach at all times. During an observation, on 4/11/2025, at 7:27 p.m., in Resident 2's room, Resident 2 laid in bed with his call light behind the head of his bed and out of reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, 4/11/2025, at 7:27 p.m., in Resident 2's room, with CNA 1, CNA 1 confirmed and stated the call light should not be behind Resident 2's head of bed and should be next to him so he could reach it and call for help if he had an emergency. During an interview, on 4/13/2025, at 9:10 a.m., with RN 6, RN 6 stated staff did not follow the P&P when it instructed the staff to make sure the call light was always placed within the resident's reach. RN 6 further stated there could be a delay in care if the call light was not within the resident's reach. During a review of the facility's P&P titled Call System, last reviewed 2/2023, the P&P indicated to make sure call light was always placed within the resident's reach.

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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. 42311 Based on interview and record review, the facility failed to ensure the Attending Physician (AP) was notified timely for one of four sampled residents (Resident 16) when Resident 16 had a change in condition. This failure resulted in delay of obtaining appropriate instructions from the AP for proper management of Resident 16's health condition. Findings: During a review of Resident 16's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 16 on 1/1/2025 due to chronic respiratory failure (occurs when the respiratory system cannot adequately provide oxygen to the body). During a review of Resident 16's Physician's Order dated 1/22/2024, the Physician's Order indicated Resident 16's diagnoses included seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), traumatic brain injury (TBI- a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) from motor vehicle accident, and respiratory failure with tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck). During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool), dated 3/10/2025, the MDS indicated Resident 16 was on vegetative state (a condition where someone appears awake but lacks awareness of their surroundings, and they can't engage in purposeful actions or communicate). The MDS indicated Resident 16 was dependent to staff for all activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 16 was always incontinent (unable to control) of bowel and bladder functions. During a review of Resident 16's Nurses Notes, dated 3/12/2025, timed at 11 p.m., the Nurses Notes indicated Resident 16 had a temperature of 101.2 Fahrenheit (F-unit of measuring temperature) and increased thick, dark yellow secretions. During a review of Resident 16's Nurses Notes, dated 3/13/2025, timed at 6:32 a.m., the Nurses Notes indicated the AP was notified of Resident 16's change in condition - fever, increased yellow secretions, excessive coughing and emesis (act of vomiting) twice. The Nurses notes indicated Resident 16's temperature was 99.5 F and heart rate at 120 beats per minute (bpm-normal heart rate ranges from 60-100) with oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) of 95 percent (%). The Nurses Notes indicated the AP had new orders. During a review of Resident 16's Physician's Order, dated 3/13/2025, timed at 6:25 a.m., the Physician's Order indicated the following orders: (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Blood culture (a laboratory test to check for bacteria or other germs in a blood sample), 2. Complete blood count (CBC- common blood test that measures the number and types of cells in your blood). 3. Comprehensive metabolic panel (CMP- a blood test that provides a broad overview of your body's chemical balance and metabolism), 4. Intravenous fluid (IVF-liquids injected into a person's veins through an intravenous tube) for hydration. 5. Zosyn (medication used to treat infection) IV (refers to the practice of administering fluids, medications, or other substances directly into a vein through a needle or tube), 4.5 grams (gm- unit of measurement, used for medication dosage and/or amount) every six hours for seven days for fever. 6. Vancomycin (medication used to treat infection) IV pharmacy to dose (physicians order a specific drug or drug class, and the pharmacist selects an appropriate dose for the individual patient). During a concurrent interview and record review on 4/12/2025 at 3.47 p.m., with Registered Nurse 3 (RN 3), Resident 16's Nurses Notes dated 3/12/2025 to 3/13/2025 were reviewed. RN 3 stated Resident 16 had a change in condition when he (Resident 16) had a fever and excessive secretions on 3/12/2025 at 11 p.m. RN 3 stated the Nurses Notes on 3/12/2025 at 11 p.m. did not indicate the AP was notified. RN 3 stated the Nurses Notes indicated the AP was notified on 3/13/2025 at 6:32 a.m., six hours after Resident 16 had a change in condition. RN 3 stated she (RN 3) would call the AP at around 11 p.m. on 3/12/2025 because of the change in condition. RN 3 stated it was a delay in the AP notification that can result in delay of care. During an interview on 4/13/2025 at 5:31 p.m. with the Director of Subacute (DSA), the DSA stated the AP should have been notified promptly when Resident 16 had a change in condition. The DSA stated the AP notification six hours after Resident 16 had a change in condition is a delay of notification. The DSA stated delay in the AP notification can result to delay in treatment. The DSA stated the importance of timely AP notification was to address the change in condition and provide care timely. During a review of the facility's policy and procedures (P&P) titled, Change in Resident Condition/Notification of Changes, dated 2/2025, the P&P indicated, To clearly define guidelines for timely notification of a change in resident condition and notification of changes as required by regulations. A. Acute Medical Change: Any sudden or serious change in a resident's condition manifested by a marked change in physical, mental, or psychosocial status. 1. The licensed nurse in charge will notify the physician promptly with a request for physician visit, recommendations, and/or evaluation. 2. If unable to contact attending physician or alternate physician timely, notify the Medical Director for follow-up of change in resident condition. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Routine Medical Changes/Need to Alter Treatment Significant: A minor change in physical, mental or psychosocial status with the potential need to discontinue an existing form of treatment or to commence a new form of treatment. 1. All signs and symptoms of the condition change will be communicated to the physician promptly. 2. The nurse in charge is responsible for notification of physician and family or legal representative prior to end of assigned shift when a change in a resident's condition is noted. 3. If unable to reach physician or family/legal representatives, the notifications, including calls to physicians or exchanges/requesting callbacks, will be documented on the Nursing Flow sheet. 4. If the physician has not returned the call by the end of the shift, the incoming nurse will be notified for follow up.

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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. 49947 Based on observation, interview, and record review the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure injuries (PI/PU - localized damage to the skin and/or underlying tissue usually over a bony prominence) by failing to ensure heels were floated on two pillows for one of one sampled resident (Resident 14) during a random observation. This deficient practice had the potential for Resident 14's deep tissue injury (damage to the deeper layers of the skin and underlying tissues, like muscle and fat, caused by pressure or shear forces) to reappear or form new PI. Findings: During a review of Resident 14's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 14 on 1/12/2025. During a review of Resident 14's History and Physical (H&P), dated 12/25/24, the H&P indicated Resident 14 was unable to provide meaningful information. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2025, the MDS indicated Resident 14 was rarely/never understood and never/rarely made decisions. The MDS further indicated Resident 14 was dependent on facility staff for activities such as eating, hygiene and dressing. During a review of Resident 14's Physician's Orders, dated between 4/1/2025 to 4/30/2025, the physician's orders indicated the resident had diagnoses including chronic respiratory failure (a long-term condition where the lungs are unable to adequately exchange oxygen [gas used for breathing]and carbon dioxide [gas given off from breathing]) with vent (machine that breathes for a person when they cannot breathe on their own), chronic encephalopathy(group of conditions that cause brain dysfunction), and dementia (a progressive state of decline in mental abilities). The Physician's Orders further indicated Resident 14 was ordered to float heels on two pillows on 1/16/2025. During a review of Resident 14's Deep Tissue Injury Care Plan (CP), initiated on 1/16/2025, the CP indicated Resident 14 had a dry, intact, dark brown wound bed on the left heel. The CP further indicated interventions to float heels on two pillows. During a concurrent observation and interview, 4/13/2025, at 7:46 a.m., inside Resident 14's room, with Registered Nurse (RN) 3, Resident 14 laid in bed and RN 3 lifted the covers from Resident 14's legs. Resident 14's heels touched the mattress and RN 3 stated Resident 14's heels were touching the mattress, and they should be propped up on two pillows so they would float. RN 3 stated Resident 14 has an order to float her heels on two pillows to prevent skin breakdown and it was not followed by the facility staff. RN 3 further stated the deep tissue injury to Resident 14's heel has resolved, but the facility must continue to float her heels to prevent another one. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Pressure/Vascular (relating to blood vessels) Ulcer Management last reviewed 2/2025, the P&P indicated to use pressure relief device, as appropriate.

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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. 49947 Based on observation, interview, and record review, the facility failed to provide an environment that is free from accidents or hazards by failing to ensure the brakes were set on the hospital bed for one of four sampled residents (Resident 14) during a random observation. This deficient practice placed Resident 14 at risk for hazard or injury such as a fall. Findings: During a review of Resident 14's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 14 on 1/12/2025. During a review of Resident 14's History and Physical (H&P), dated 12/25/24, the H&P indicated Resident 14 was unable to provide meaningful information. During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2025, the MDS indicated Resident 14 was rarely/never understood and never/rarely made decisions. The MDS further indicated Resident 14 was dependent on facility staff for activities such as eating, hygiene and dressing. During a review of Resident 14's Physician's Orders, dated between 4/1/2025 to 4/30/2025, the physician's orders indicated the resident had diagnoses including chronic respiratory failure (a long-term condition where the lungs are unable to adequately exchange oxygen [gas used for breathing]and carbon dioxide [gas given off from breathing]) with vent (machine that breathes for a person when they cannot breathe on their own), chronic encephalopathy(group of conditions that cause brain dysfunction), and dementia (a progressive state of decline in mental abilities). During an observation, 4/11/2025, at 7:14 p.m., inside Resident 14's room, Resident 14 laid in bed and the brakes to her bed were unlocked without staff in the room. During a concurrent observation and interview, 4/11/2025, at 7:17 p.m., inside Resident 14's room, with Registered Nurse (RN) 4, Resident 14 was in bed and RN 3 looked down at the brakes and stated it was dangerous to have the brakes unlocked on Resident 14's bed and could cause a fall or injury. During a review of the [Hospital Bed 1] Medical Bed operations manual, undated, the manual indicated to always keep the brakes applied when a resident is on the bed. The operations manual further indicated after the brake is applied, push on the bed to ensure the brakes are locked.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 49947 Based on observation, interview, and record review, the facility failed to ensure a resident who was incontinent (lacks voluntary control over urination) of bladder (organ in the pelvis that stores urine) received appropriate treatment and services to prevent urinary tract infections (UTI - an infection in the bladder/urinary tract) for one of five sampled residents (Resident 2) observed during the screening process by failing to keep Resident 2's urinary catheter tubing (also known as an indwelling catheter, a hollow tube inserted into the bladder to drain or collect urine) from looping and allowing the contents to flow freely into the urinary catheter bag (container that connects to a urinary catheter and collects urine). This deficient practice had the potential for Resident 2 to develop catheter associated urinary tract infection (CAUTI - an infection of the urinary tract caused by a urinary catheter). Findings: During a review of Resident 2's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 2 on 4/4/2025. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2025, the MDS indicated Resident 2 was rarely/never understood and never/rarely made decisions. The MDS further indicated Resident 2 was dependent on facility staff for activities such as eating, hygiene and dressing. During a review of Resident 2's Nutritional Screening, dated 4/11/2025, the Nutritional Screening indicated Resident 2's diagnoses included chronic respiratory failure (a long-term condition where the lungs are unable to adequately exchange oxygen [gas used for breathing]and carbon dioxide [gas given off from breathing]), chronic encephalopathy (group of conditions that cause brain dysfunction), tracheostomy, cerebral palsy (a group of disorders that affect movement and posture due to damage to the developing brain before, during, or shortly after birth), and seizure disorder (a sudden, temporary disturbance of the brain's electrical activity). During a review of Resident 2's Care Plan (CP) titled, Potential for infection [related to] presence of indwelling catheter, dated 4/4/2025, the CP indicated an intervention to check that the urinary catheter tubing was not kinked and there is a free flow of urine at all times. During an observation, on 4/13/2025, at 7:40 a.m., inside Resident 2's room, Resident 2 laid in bed with a urinary catheter bag hanging on the right side of the resident's bedframe. The urinary catheter tubing hung below the middle-right side of the bed and had a large loop. The looped portion of the urinary catheter tubing contained yellow liquid with a small amount of sediment. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, 4/13/2025, at 7:46 a.m., inside Resident 2's room, with Registered Nurse (RN) 6, RN 6 confirmed and stated Resident 2's urinary catheter tubing was looped and contained yellow liquid with white sediment. RN 6 stated the urinary catheter tubing should be straight in order drain the urine into the urinary catheter bag. RN 6 further stated if the urine is not draining properly, Resident 2 can possibly get an infection because the urine might backflow into his body. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Routine Daily, last reviewed 2/2025, the P&P indicated to ensure the catheter tubing is free of kinks and obstruction, allowing urine to flow freely.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 49947 Based on observation, interview, and record review, the facility failed administer total parenteral nutrition (TPN - a method of feeding that delivers nutrients directly into the bloodstream through a hollow tube, bypassing the digestive system) consistent with professional standards of practice by failing to label the TPN bag and PICC (peripherally inserted central catheter - thin, flexible tube inserted into a vein in the upper arm and guided to a large vein near the heart) line tubing with the date and time it was started on one of one resident (Resident 2) during a random screening. This deficient practice had the potential to increase Resident 2's risk for complications from TPN such as bacteria growth in the tubing. Findings: During a review of Resident 2's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 2 on 4/4/2025. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/7/2025, the MDS indicated Resident 2 was rarely/never understood and never/rarely made decisions. The MDS further indicated Resident 2 was dependent on facility staff for activities such as eating, hygiene and dressing. During a review of Resident 2's Nutritional Screening, dated 4/11/2025, the Nutritional Screening indicated Resident 2's diagnoses included chronic respiratory failure (a long-term condition where the lungs are unable to adequately exchange oxygen [gas used for breathing]and carbon dioxide [gas given off from breathing]), chronic encephalopathy (group of conditions that cause brain dysfunction), tracheostomy, cerebral palsy (a group of disorders that affect movement and posture due to damage to the developing brain before, during, or shortly after birth), and seizure disorder (a sudden, temporary disturbance of the brain's electrical activity). During a review of Resident 2's Care Plan (CP) titled, Potential for Infection Related to the Presence of a PICC Line, the CP indicated an intervention to change tubing according to protocol. During an observation, on 4/13/2025, at 7:40 a.m., inside Resident 2's room, Resident 2 laid in bed with TPN running and connected to his PICC line on his right upper arm. The TPN bag and tubing did not have a date or time it was started. During a concurrent observation and interview, 4/13/2025, at 7:46 a.m., inside Resident 2's room, with Registered Nurse (RN) 6, RN 6 confirmed and stated Resident 2's TPN bag and tubing were not labeled with the date and time it was started. RN 6 stated it was the facility's practice and policy to indicate the date and time started on every bag of TPN, medication, and tubing so other nurses will know what time it was started and to reduce confusion. RN 6 further stated Resident 2 had the potential to acquire an infection from the unlabeled TPN bag and tubing. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, IV (intravenous - through the vein) Therapy Protocol, last reviewed 2/2025, the P&P indicated the nurse starting the bag dates and initials the bag and can be done by writing on the resident's name label or use an auxiliary (something that gives aid/helps of any kind) label.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43988 Based on observation, interview and record review, the facility failed to ensure respiratory care provided to residents were consistent with professional standards of practice for one (1) of 1 sampled residents (Resident 9) reviewed for respiratory care by failing to ensure the Yankauer suction catheter (long plastic tool used to remove secretions [thick or thin sticky fluids from the mouth and throat]) was labeled with the date when the catheter will be changed next. This deficient practice placed the resident at risk for acquiring infection from possibly contaminated equipment. Findings: During a review of Resident 9's Admission/Registration form, the Admission/Registration form indicated the facility originally admitted the resident on 10/9/2018 and readmitted in the facility on 12/31/2024 During a review of Resident 9's History and Physical (H&P), dated 1/2/2025, the H&P indicated Resident 9 had diagnoses of respiratory failure (a long-term condition in which your lungs have a hard time loading your blood with oxygen and can leave you with low oxygen), ventilator (a medical device to help support or replace breathing) dependent, and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) disorder. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 1/17/2025, the MDS indicated Resident 9 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 9 received suctioning treatments. During a review of Resident 9's Physician's Orders, dated 10/9/2018, the Physician's Orders indicated an order to suction retained or increased secretions every two (2) hours and as needed. During a review of Resident 9's care plan (CP) on potential for infection, last revised on 12/31/2024, the CP indicated to suction every 2 hours and as needed retained or increased secretions and oral care every shift and as needed as a few of the interventions to minimize risk for signs and symptoms of respiratory infection. During an observation, on 4/11/2025, at 7:02 p.m., inside Resident 9's room, Resident 9's Yankauer suction catheter, inside an opened storage bag, did not have a label with an opened date. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview, on 4/11/2025, at 7:10 p.m., inside Resident 9's room, with Licensed Vocational Nurse (LVN) 9, LVN 9 stated night shift licensed nurses change all resident respiratory equipment, including Yankauer suction catheters, every morning at 6 am prior to end of shift and place a sticker indicating the date and time the equipment will be changed next. LVN 9 stated she did not know what happened with the sticker indicating that she changed the Yankauer suction catheter on 4/11/2025 at 6 a.m. and will be changed 4/12/2025 at 6 a.m. LVN 9 stated if the suction catheter was changed during the morning shift, the storage bag should have a sticker indicating to change on 4/12/2025 at 6 a.m. LVN 9 stated Resident 9's Yankauer suction catheter should have a sticker of when it will be changed next so the staff would know that the Yankauer suction catheter was changed as scheduled and was not old which placed Resident 9 at risk for infection if the suction catheter was possibly contaminated. During an interview, on 4/13/2025, at 8:28 a.m., with the Director of Sub Acute (DSA), the DSA stated all respiratory equipment in the resident room such as the suction canisters and Yankauer suction catheters are changed every morning by the night shift licensed nurse prior to end of shift. The DSA stated Resident 9's Yankauer suction catheter should have indicated the date and time of when it would be changed next. The DSA stated when the staff change the Yankauer suction catheter to a new one and indicate the date and time of when it would be changed, the other staff would know that the suction catheter was not old. The DSA stated an unlabeled Yankauer suction catheter could possibly be contaminated which can lead to residents acquiring an infection. During a review of the facility's policy and procedure (P&P) titled, Changing & Emptying of Suction Set Ups, last reviewed on 2/2025, the P&P indicated a purpose to minimize risk of infection. The P&P further indicated: - All suction extension tubing and Yankauer suction devices will be changed daily and as needed and the Yankauer rinsed after each use. - During equipment changing, gather needed clean or sterile disposable items, label with date it will be changed, and initials of staff member making the change.

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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** 42311 Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) for three of five sampled residents (Residents 4, 3, and 18) by: 1. Failing to ensure Registered Nurse (RN) 2 administered 20-50 milliliter (ml - unit of volume) of water after medication administration to Resident 4 as per physician's order. 2. Failing to ensure Licensed Vocational Nurse (LVN) 1 flushed (also known as rinsing) Resident 3's gastrostomy tube (g-tube, a feeding tube inserted into the stomach through the abdominal wall, used to deliver nutrition, fluids, and medications directly to the stomach when someone cannot eat or drink adequately by mouth) with water in between medication administration as per facility's policy and procedures. 3. Failing to ensure LVN 2 flushed Resident 18's g-tube with water in between medication administration as per facility's policy and procedure. These failures had the potential to result in medication error and can result in medication drug interaction (a change in how the body responds to one medication when it's taken with another, or when it interacts with food, drinks, or even certain medical conditions can make a drug less effective, cause unwanted side effects, or even increase the action of a drug). Findings: 1. During a review of Resident 4's Physician's Orders, dated 10/18/2024, the Physician's order indicated the facility admitted Resident 4 on 10/18/2024, with diagnoses that included chronic respiratory failure (the lungs are unable to get enough oxygen into the blood or get rid of enough carbon dioxide, leading to breathing difficulties and fatigue over a long period), ventilator dependent (a resident requires medical device to help support or replace breathing), and dysphagia (difficulty swallowing). The Physician's Order indicated to flush feeding tube (g-tube) with 20-50 ml of water before and after medication administration. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2025, the MDS indicated Resident 4's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions were severely impaired. The MDS indicated Resident 4 was dependent to staff for all activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 4 had a feeding tube (g-tube). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 4's Care Plan on at risk for aspiration (accidentally inhaling something other than air into your lungs, like food, water, or stomach contents) due to tube feeding (g-tube), dated 1/2/2025, the Care Plan indicated an intervention to maintain patency of feeding tube (g-tube), by flushing with water at a minimum of one ounce (oz = 30 ml) every shift and after medication administration. During a concurrent observation and interview on 4/12/2025 at 8:27 a.m., with RN 2, inside Resident 4's room, observed RN 2 administer 30 ml of water in between medication administration but administered 10 ml of water after the third and last medication administration. RN 2 stated the last medication she administered was Protonix (medication used to decrease acid in the stomach) then flushed Resident 4's g-tube with 10 ml of water. During a concurrent interview and record review on 4/12/2025 at 11:23 a.m., with RN 2, Resident 4's Physician's Order dated 10/18/2024, was reviewed. RN 2 stated the Physician's Order indicated to flush g-tube with 20-50 ml of water after medication administration. RN 2 stated 10 ml of water flush may not be enough and can clog Resident 4's g-tube. During an interview on 4/13/2025 at 5:31 p.m., with the Director of Subacute (DSA), the DSA stated g-tube should be flushed with 30 ml to 50 ml of water before and after medication administration. The DSA stated medication cannot be fully absorb if RN 2 flushed only 10 ml of water after medication administration. The DSA stated the importance of flushing g-tube with enough water was for hydration and also to make sure all the medication will reach the resident and not just left in the g-tube. The DSA stated the facility's policy was to flush g-tube with water after medication administration. 2. During a review of Resident 3's Physician's Order dated 2/7/2025, the Physician's Order indicated the facility admitted Resident 3 on 2/7/2025, with diagnoses that included chronic hypoxemic respiratory failure (a long-term condition where the lungs struggle to provide enough oxygen to the blood), tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe)] from outside the neck) and pneumonia (an infection/inflammation in the lungs). The Physician's Order indicated to flush feeding tube (g-tube) with 20-50 ml of water before and after giving medication. During a review of Resident 3's MDS dated [DATE], the MDS indicated Resident 3's cognitive skills for decision making were severely impaired. The MDS indicated Resident 3 was dependent to staff for ADL. The MDS indicated Resident 3 had a feeding tube (g-tube). During a review of Resident 3's Care Plan on the resident's risk for aspiration due to tube feeding (g-tube), dated 1/2/2025, the Care Plan indicated an intervention to maintain patency of feeding tube by flushing with water at a minimum of 30 ml every shift and after medication administration. During an observation on 4/12/2025 at 9 a.m., observed LVN 1 administer crushed levetiracetam (also known as Keppra, medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] mixed with water to Resident 3's g-tube. Observed undissolved Keppra remaining in the medication cup and LVN 1 poured water in the remaining Keppra and administered to Resident 3's g-tube. Observed then LVN 1 administer crushed fluconazole (medication used to treat serious fungal [organisms that can live in various environments like soil, air, plants, and the human body] or yeast [a living microorganism naturally present in the environment and in our gut] infection) mixed with water thereafter. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/12/2025 at 5:36 p.m., with the Pharmacist (Pharm 1), Pharm 1 stated Keppra followed by fluconazole g-tube administration had moderate interaction (signifies a level of interaction that may warrant adjustments or monitoring by a healthcare provider) that could cause Resident 3 to be at low risk for QTc prolongation (means it takes the heart longer than usual to fully recharge between beats). During a concurrent interview and record review on 4/12/2025, at 7:05 p.m., with Pharm 1, an online Drug Interaction dated 2025 provided by Pharm 1 was reviewed. The Drug Interaction indicated Keppra was a QT prolonging agents (Intermediate Risk-moderate chance of a negative outcome or potential issues) and fluconazole was a QT-prolonging agents (moderate risk-these drugs can increase the risk of Torsade's de Pointes [TdP-a potentially life-threatening heart rhythm disturbance]). The Drug Interaction indicated no action was required for the majority of residents. The Drug Interaction indicated increased electrocardiogram (ECG-a test that records the electrical activity of the heart, helping doctors diagnose and monitor heart condition) monitoring may be considered in residents at high risk for QT interval prolongation (example older age, female .).The Drug Interaction indicated the risk of combining these agents is unclear, but product labelling for at least some of these indeterminate risk drugs suggest additional caution and increased ECG monitoring may be warranted when combined with drugs that prolong the QT interval. 3. During a review of Resident 18's Physician's Order, dated 7/25/2024, the Physician's Order indicated the facility admitted Resident 18 on 7/25/2024, with diagnoses that included chronic respiratory failure, ventilator dependent, and dysphagia with gastrostomy tube. The Physician's Order indicated flush feeding tube (g-tube) with 20-50 ml of water before and after giving medication. During a review of Resident 18's MDS dated [DATE], the MDS indicated Resident 18's cognitive skills for decision making were severely impaired. The MDS indicated Resident 18 was dependent to staff for ADL. The MDS indicated Residents 18 had a feeding tube (g-tube). During a review of Resident 18's Care Plan on the resident's risk for aspiration due to tube feeding dated 12/31/2024, the Care Plan indicated an intervention to maintain patency of feeding tube by flushing with water at a minimum of 30 ml every shift and after medication administration. During a concurrent observation and interview on 4/13/2025 at 12:30 p.m., with LVN 2, at Resident 18's bedside, observed LVN 2 administer liquid docusate (also known as Colace, medication used to soften stool) and then followed by crushed bethanechol (also known as Urecholine, medication used to treat urinary retention [the inability to completely empty the bladder]) mixed with water to Resident 18's g-tube. LVN 2 stated she missed flushing Resident 18's g-tube in between the two medications (Colace and Urecholine). LVN 2 stated she should have flushed Resident 18's g-tube with water in between medication administration. During an interview on 4/13/2025 at 5:31 p.m., with the DSA, the DSA stated g-tube should be flushed with water in between medication administration. The DSA stated LVN 1 and LVN 2 should have given free water in between medication administration to prevent possible drug interaction. The DSA stated it is the facility's policy to flush g-tube in between medication administration. During a review of facility's policy and procedure (P&P) titled, Medication Administration dated 2/2025, the P&P indicated, Procedure: Tube Administration , . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. Draw the liquefied medications into the feeding syringe or pour into connected feeding syringe by gravity. Allow medications to flow by gravity through the enteral tube. Gentle pressure with the syringe plunger may be used, if necessary. Never 'force' medications/fluids through tubing. 11. Rinse medication cup and administering rinsing to assure compete dose. 12. Flush tube with a minimum of 50 ml of water. 13. Reconnect the administration set tubing, unclamp and start the enteral pump (a medical device that is used to deliver nutrients directly into the gastrointestinal tract of a resident who is unable to take food or liquids orally) if needed and double check the flow rate.

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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** 42311 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five percent (%- per one hundred), four medication errors out of 26 total opportunities contributed to an overall medication error rate of 15.38% affecting two of five sampled residents (Resident's 3 and 18) observed for medication administration by: 1. Failing to ensure Licensed Vocational Nurse 1 (LVN 1) flushed Resident 3's gastrostomy tube (g-tube, a feeding tube inserted into the stomach through the abdominal wall, used to deliver nutrition, fluids, and medications directly to the stomach when someone cannot eat or drink adequately by mouth) with water in between medication administration as per facility's policy and procedure. 2. Failing to ensure LVN 2 flushed Resident 18's g-tube with water in between medication administration as per facility's policy and procedure. These failures had the potential to result in residents experiencing medication adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and medication error. Findings: 1. During a review of Resident 3's Physician's Order, dated 2/7/2025, the Physician's Order indicated the facility admitted Resident 3 on 2/7/2025, with diagnoses that included chronic hypoxemic respiratory failure (a long-term condition where the lungs struggle to provide enough oxygen to the blood), tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe)] from outside the neck) and pneumonia (an infection/inflammation in the lungs). The Physician's Order indicated flush feeding tube (g-tube) with 20-50 milliliter (ml-unit of volume) of water before and after giving medication. During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 2/20/2025, the MDS indicated Resident 3's cognitive skills for decision making were severely impaired. The MDS indicated Resident 3 was dependent to staff for ADL. The MDS indicated Resident 3 had a feeding tube (g-tube). During a review of Resident 3's Care Plan on risk for aspiration due to tube feeding (g-tube), dated 1/2/2025, the Care Plan indicated an intervention to maintain patency of feeding tube by flushing with water at a minimum of 30 ml every shift and after medication administration. During an observation on 4/12/2025, at 9 a.m., observed LVN 1 administer crushed Keppra (medication used to treat seizures [a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness] mixed with water to Resident 3's g-tube. Observed undissolved Keppra remaining in the medication cup and LVN 1 poured water in the remaining Keppra and administered to Resident 3's g-tube. Observed LVN 1then administer crushed fluconazole (medication used to treat serious fungal [organisms that can live in various environments like soil, air, plants, and the human body] or yeast [a living microorganism naturally present in the environment and in our gut] infection) mixed with water thereafter. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/12/2025, at 5:36 p.m., with th e Pharmacist (Pharm 1), Pharm 1 stated Keppra followed with fluconazole g-tube administration had moderate interaction (signifies a level of interaction that may warrant adjustments or monitoring by a healthcare provider) that could cause Resident 3 to be at low risk for QTc prolongation (means it takes the heart longer than usual to fully recharge between beats). During a concurrent interview and record review on 4/12/2025, at 7:05 p.m., with Pharm 1, an online Drug Interaction dated 2025 provided by the Pharm 1 was reviewed. The Drug Interaction indicated Keppra was a QT prolonging agents (Intermediate Risk-moderate chance of a negative outcome or potential issues) and fluconazole was a QT-prolonging agents (moderate risk-these drugs can increase the risk of Torsade's de Pointes [TdP-a potentially life-threatening heart rhythm disturbance]). The Drug Interaction indicated no action was required for the majority of residents. The Drug Interaction indicated increased electrocardiogram (ECG-a test that records the electrical activity of the heart, helping doctors diagnose and monitor heart condition) monitoring may be considered in residents at high risk for QT interval prolongation (example older age, female .).The Drug Interaction indicated the risk of combining these agents is unclear, but product labeling for at least some of these indeterminate risk drugs suggest additional caution and increased ECG monitoring may be warranted when combined with drugs that prolong the QT interval. 2. During a review of Resident 18's Physician's Order, dated 7/25/2024, the Physician's Order indicated the facility admitted Resident 18 on 7/25/2024, with diagnoses that included chronic respiratory failure, ventilator dependent (a resident requires medical device to help support or replace breathing), and dysphagia (swallowing problem) with gastrostomy tube. The Physician's Order indicated flush feeding tube (g-tube) with 20-50 ml of water before and after giving medication. During a review of Resident 18's MDS dated [DATE], the MDS indicated Resident 18's cognitive skills for decision making were severely impaired. The MDS indicated Resident 18 was dependent to staff for ADL. The MDS indicated Residents 18 had a feeding tube (g-tube). During a review of Resident 18's Care Plan on risk for aspiration due to tube feeding dated 12/31/2024, the Care Plan indicated an intervention to maintain patency of feeding tube by flushing with water at a minimum of 30 ml every shift and after medication administration. During a concurrent observation and interview on 4/13/2025, at 12:30 p.m., with LVN 2, at Resident 18's bedside, observed LVN 2 administer liquid Colace (medication used to soften stool) and then followed by crushed Urecholine (medication used to treat urinary retention [the inability to completely empty the bladder]) mixed with water to Resident 18's g-tube. LVN 2 stated she (LVN 2) missed flushing Resident 18's g-tube in between the two medication (Colace and Urecholine). LVN 2 stated she (LVN 2) should have flushed Resident 18's g-tube with water in between medication administration. During an interview on 4/13/2025 at 5:31 p.m., with the Director of Subacute (DSA), the DSA stated g-tube should be flushed with water in between medication administration. The DSA stated not flushing Resident 3 and 18's g-tube in between medication administration was a medication error. The DSA stated LVN 1 and LVN 2 should have given free water in between medication administration to prevent possible drug interaction. The DSA stated it is the facility's policy to flush g-tube in between medication administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of facility's policy and procedure (P&P) titled , Medication Administration dated 2/2025, the P&P indicated, Procedure: Tube Administration, . 10. Draw the liquefied medications into the feeding syringe or pour into connected feeding syringe by gravity. Allow medications to flow by gravity through the enteral tube. Gentle pressure with the syringe plunger may be used, if necessary. Never 'force' medications/fluids through tubing. 11. Rinse medication cup and administering rinsing to assure compete dose. 12. Flush tube with a minimum of 50 ml of water. 13. Reconnect the administration set tubing, unclamp and start the enteral pump (a medical device that is used to deliver nutrients directly into the gastrointestinal tract of a resident who is unable to take food or liquids orally) if needed and double check the flow rate .

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Sherman Oaks Hospital Snf Dp	4929 Van Nuys Blvd Sherman Oaks, CA 91403

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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. 49947 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when the kitchen failed to label: 1 box of bacon 1 box of sausages 1 tray of eggs These failures had the potential to result in harmful bacteria growth and cross contamination (a transfer of harmful bacteria from one place to another or one object to another) that could lead to foodborne illness (illness caused by food contaminated with bacteria, viruses, and other toxins) in one out of twenty medically compromised residents who receive food from the kitchen. Findings: During an initial kitchen tour observation, on 4/11/2025, at 7:32 p.m., inside refrigerator 10, a large box of sausage, a large box of bacon, and a large open carton of eggs were unsealed and without an open or use by date written on the two boxes and the carton of eggs. During a concurrent observation and interview, with the Dietary Clerk (DC), on 4/11/2025, at 6:20 p.m., the DC looked into refrigerator 10 and stated the cook is in charge of labeling items and the cook did not label the boxes of sausage, bacon, and eggs with an open/best by date. The DC further stated without an open date, the facility will not know if the food is safe to serve. During an interview, on 4/13/2025, at 2:15 p.m., with the Food and Nutrition Director (FND), the FND stated every food item received must have a received and best by date and every food item opened must have an open date to prevent food borne illnesses. During a review of the facility's policy and procedure (P&P) titled, Food Storage, last revised on 2/2025, the P&P indicated food are to be stored in a safe and sanitary manner to prevent chemical and bacteriological contamination as well as time/temperature abuse. The P&P further indicated to rotate produce, frozen foods, dairy products etc. so that the oldest dates are used first.

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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 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** 42311 Based on observation, interview, and record review. the facility failed to maintain accurate and complete medical record for two of five sampled residents (Residents 18 and 19) by: 1. Failing to ensure Resident 18's medical record was accurate when the written order for docusate sodium (medication used to soften stool) was in soft gel (capsule) form and the electronic order was in liquid form. 2. Failed to ensure Resident 19's medical record was accurate when Licensed Vocational Nurse 7 (LVN 7) documented presence of bleeding and administered Eliquis (medication used to prevent blood clot). These failures had the potential to cause confusion in care and the medical records containing inaccurate documentation. Findings: 1. During a review of Resident 18's Physician's Order, dated 7/25/2024, the Physician's Order indicated the facility admitted Resident 18 on 7/25/2024, with diagnoses that included chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood), ventilator dependent (a person that requires a medical device to help support or replace breathing) and dysphagia (swallowing difficulty) with gastrostomy tube (g-tube, a feeding tube inserted into the stomach through the abdominal wall, sued to deliver nutrition, fluids and medications). The Physician's Order indicated docusate sodium soft gel 100 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) capsule, give one capsule via g-tube three times a day as stool softener. During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 2/4/2025, the MDS indicated Resident 18's cognitive (mental action or process of acquiring knowledge and understanding) skills for decision making were severely impaired. The MDS indicated Resident 18 was dependent to staff for activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Residents 18 had a feeding tube (g-tube). During an observation on 4/12/2025, at 8:44 a.m., inside Resident 18's room, observed LVN 1 administer docusate sodium 50 mg/5 milliliter (ml-unit of measurement), gave 10 ml liquid to Resident 18's g-tube. During a concurrent interview and record review on 4/12/2025, at 3:37 p.m., with Minimum Data Set Nurse (MDSN), Resident 18's Physician's Order dated 7/25/2024, was reviewed. The Physician's Order indicated docusate sodium soft gel 100 mg capsule, give one capsule via g-tube three times a day as stool softener. The MDSN stated the physician's order should have been clarified with the physician. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/2025 at 3:47 p.m., with Registered Nurse (RN) 3, RN 3 stated there were inaccurate documentation between the written order for docusate sodium compared to the electronic order. RN 3 stated order should have been corrected and should match during the monthly recapitulation of physician order (a summary or review of all orders placed within a given month). RN 3 stated the physician should have been called to change the physician's order to liquid. 2. During a review of Resident 19's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 19 on 2/12/2025, with diagnoses that included acute hypoxic respiratory failure (a serious condition where the lungs fail to adequately oxygenate the blood, leading to low oxygen levels in the bloodstream). During a review of Resident 19's Physician's Order dated 2/12/2025, the Physician's Order indicated Resident 19 had diagnoses that included acute hypoxic respiratory failure, tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck) and sepsis (a serious condition in which the body responds improperly to an infection). During a review of Resident 19's Care Plan on at risk for bruise (a discoloration of the skin caused by blood leaking from broken blood vessels beneath the skin), skin tear and abrasion (a superficial rub or wearing off of the skin, usually caused by a scrape or a brush burn) due to anticoagulant therapy (also known as blood thinning, involves using medications to reduce the ability of blood to clot) dated 2/14/2025, the Care plan indicated the following interventions: 1. Monitor and report any bruises, skin tears, and abrasions. 2. Monitor for signs and symptoms of bleeding, report hematuria (blood in the urine), blood stool, nose bleeding, hemoptysis (coughing of blood), and bleeding gums. During a review of Resident 19's MDS, dated [DATE], the MDS indicated Resident 19 was on vegetative state. The MDS indicated Resident 19 was dependent to staff for all ADLs. The MDS indicated Resident 19 was on anticoagulant. During a review of Resident 19's Physician's Order dated 2/21/2025, the Physician's Order indicated resume Eliquis 5 mg via g-tube every 12 hours. During a concurrent interview and record review on 4/12/2025 at 8:05 p.m., with the MDSN, Resident 19's Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/8/2025 for Eliquis was reviewed. The MAR indicated Eliquis was given to Resident 19 on 4/8/2025 at 9:33 p.m., with documented signs of bleeding. The MDSN stated if bleeding was noted, Eliquis should have been held (not administered). During an interview on 4/13/2025, at 5:31 p.m. with the Director of Subacute (DSA), the DSA stated Eliquis is an anticoagulant and had a side effect of bleeding. The DSA stated residents on Eliquis are monitored for signs of bleeding and if residents had signs of bleeding, Eliquis should have been held to prevent further bleeding that can lead to complication. The DSA stated LVN 7 made an incorrect documentation. The DSA stated the importance of accurate documentation was to prevent miscommunication. The DSA stated the facility's policy was to document accurately the things observed and care provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Charting Guidelines dated 6/2024 was reviewed. The (P&P) indicated, It is the policy of this facility that: 1. All documentation will be completed as required for each resident. 2. Charting should include all assessments of resident condition, all interventions taken to resolve a problem and the progress/lack of progress with the written care plan 8. Keep entries factual and specific. They must be accurate and informative. Document any changes in resident condition as well as steps taken in response to the change. 9. Document normal findings as well as abnormal findings as this shows that the resident was being assessed. 10. When physician intervention is required, document the time the physician was contacted and the time he responded. When new orders are implemented, the chart needs to reflect the resident notification and response to the intervention.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42311 Based on interview, and record review, the facility failed to implement policy for antibiotic (medication used to treat infection) stewardship (efforts in doctors' offices, hospitals, long-term care facilities, and other health care settings to ensure that antibiotics are used only when necessary and appropriate, means prescribing the right drug at the right dose at the right time for the right duration) for two of five sampled residents (Resident 16 and 19) by: 1. Failing to monitor Resident 16 for antibiotic use, side effects or adverse reaction (unintended pharmacologic effects that occur when a medication is administered correctly while a side effect is a secondary unwanted effect). 2. Failing to ensure Infection Control Surveillance Log (record that involves the systematic collection, analysis, and interpretation of data related to infections within a healthcare setting) for Resident 19's antibiotics was completely filled up in 3/2025. These failures had the potential to increase antibiotic resistance (don't respond to a drug) from unnecessary or inappropriate antibiotic use. Findings: a. During a review of Resident 16's Physician's Order dated 1/22/2024, the Physician's Order indicated the facility admitted Resident 16 on 1/22/2024, with diagnoses that included seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), traumatic brain injury (TBI- a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) from motor vehicle accident, and respiratory failure (occurs when the respiratory system cannot adequately provide oxygen to the body), with tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck). During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) dated 3/10/2025, the MDS indicated Resident 16 was on vegetative state (a condition where someone appears awake but lacks awareness of their surroundings, and they cannot engage in purposeful actions or communicate). The MDS indicated Resident 16 was dependent to staff for all activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 16 was always incontinent (unable to control) of bowel and bladder functions. During a review of Resident 16's Nurses Notes dated 3/12/2025, timed at 11 p.m., the Nurses Notes indicated Resident 16 had a temperature of 101.2 Fahrenheit and an increased thick, dark yellow secretion. During a review of Resident 16's Physician's Order dated 3/13/2025, timed at 6:25 a.m., the Physician's Order indicated the following orders. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Zosyn (medication used to treat infection) 4.5 grams (gm- unit of measurement, used for medication dosage and/or amount) intravenous (IV- refers to the practice of administering fluids, medications, or other substances directly into a vein through a needle or tube) every six hours for seven days due to fever (a rise in body temperature, typically indicated by a reading of 100.4 F or higher). 2. Vancomycin (medication used to treat infection) IV, pharmacy to dose (physicians order a specific drug or drug class, and the pharmacist selects an appropriate dose for the individual patient). During a review of Resident 16's Physician's Order dated 3/13/2025, timed at 10:26 a.m., the Physician's Order indicated to start Vancomycin 1250 mg IV every 12 hours until further orders for fever. During a review of Resident 16's Nurses Notes from 3/13/2025, to 3/20/2025, the Nurses Notes indicated no documented monitoring for Zosyn and Vancomycin use and adverse reactions. During a review of Resident 16's Care plan on IV antibiotic treatment related to fever dated 3/14/2025, the Care Plan indicated an intervention to observe Resident 16 for any adverse reactions to antibiotic such as rash (a change in the appearance or feel of the skin, often appearing as redness, bumps, or itching), nausea, vomiting or gastrointestinal distress (encompasses a range of uncomfortable digestive symptoms like abdominal pain, bloating, gas, and changes in bowel habits). During an interview on 4/11/2025, at 7:29 p.m., with the Minimum Data Set Nurse (MDSN), the MDSN stated nurses monitors resident for antibiotic use and nurses documents it in Nurses Notes. During an interview on 4/12/2025, at 10:37 a.m., with the Infection Preventionist (IP), the IP stated nurses monitor the antibiotic use and nurses documents it every shift. The IP stated the importance of monitoring for antibiotic use was to make sure residents receives the antibiotic medication and it does not cause resistance. The IP stated the importance of antibiotic monitoring was to find out if the antibiotic given, works for the resident, if it was the right antibiotic, the right dose and if it was administered correctly to treat residents' infection. During an interview on 4/12/2025, at 5:26 p.m., with the Pharmacist (Pharm 1), Pharm 1 stated the Pharmacy's responsibility on antibiotic use was to monitor its usage, its side effects and how long should resident be on antibiotic. Pharm 1 stated they (Pharm 1) based their monitoring from the physician and nurses' notes. b. During a review of Resident 19's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 19 on 2/12/2025, due to acute hypoxemic respiratory failure (a serious condition where the lungs fail to adequately oxygenate the blood, leading to low oxygen levels in the bloodstream). During a review of Resident 19's Physician's Order dated 2/12/2025, the Physician's Order indicated Resident 19 had diagnoses that included acute hypoxic respiratory failure, tracheostomy and sepsis (a serious condition in which the body responds improperly to an infection). During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 was on vegetative state. The MDS indicated Resident 19 was dependent to staff for all ADL. The MDS indicated Resident 19 was on antibiotic. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 19's Physician's Order dated 3/19/2025, the Physician's Order indicated the following for wound infection. 1. Cefepime (medication used to treat infection) one gram IV every 12 hours for 14 days. 2. Fluconazole (medication used to treat fungal [diseases caused by a yeast or mold] infection) 200 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) thru gastrointestinal tube (g-tube, a medical device used to deliver fluids, nutrients, or medications directly into the gastrointestinal tract) daily for 14 days. During a review of facility's Infection Control Log dated 3/2025, the Infection Control Log indicated Resident 19's date of admission, signs and symptoms, organism location and date infection resolved were left blank. During a concurrent interview and record review on 4/11/2025, at 7:29 p.m., with the MDSN, facility's Infection Control Log dated 3/2025 was reviewed. The MDSN stated facility's Infection Control Log was incomplete for Resident 19. During a concurrent interview, and record review on 4/11/2025, at 8:06 p.m., with Registered Nurse (RN) 1, Resident 19's wound culture (a test to identify germs that may be causing an infection in a wound, it involves taking a sample from the wound and growing the germs in a laboratory to see what they are that helps healthcare providers determine the best course of treatment, such as antibiotics) dated 3/16/2025, was reviewed. RN 1 stated wound culture collected on 3/16/2025, indicated gram negative rods (bacteria that, when stained using the Gram staining method, appear pink or red instead of blue or purple, they are rod-shaped and have a unique cell wall structure with an outer membrane, making them more resistant to certain antibiotics compared to gram-positive bacteria) and moderate growth. RN 1 stated she (RN 1) did not document in the Infection Control Log the result of the wound culture. RN 1 stated the Infection Control Log also had no documented date of admission. RN 1 stated whoever receives the antibiotic order should document in the Infection Control Log. During a concurrent interview and record review on 4/12/2025 at 10:11 a.m., with the IP, the facility's Infection Control Log dated 3/2025 was reviewed. The IP stated the Infection Control Log was the antibiotic surveillance and was not complete. The IP stated the Infection Control Log had missing date of admission, some signs and symptoms, organism and date infection was resolved. The IP stated the assigned nurse, or the charge nurse completes the Infection Control Log. The IP stated the importance of monitoring use of antibiotic was to make sure it was the right medication for the organism detected. During an interview on 4/13/2025 at 5:31 p.m., with the Director of Subacute (DSA), the DSA stated the Pharmacist was tracking the antibiotics usage. The DSA stated the IP should have monitored the antibiotic use and effect of antibiotic as part of the surveillance. The DSA stated the importance of tracking and monitoring was to identify pattern and determine the infection rate if increasing or trending. The DSA stated it is the facility's policy to perform antibiotic surveillance as part of the antibiotic stewardship. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of facility's policy and procedure (P&P) titled, Antibiotic Stewardship dated 2/2024, the P&P indicated, The Antibiotic Stewardship Program (ASP) includes a subcommittee of staff to promote the appropriate antimicrobial usages, to monitor the progress, to recommend and to modify therapy as indicated, and to perform functions for a successful ASP. The ASP team, as lead by the Infectious Disease specialist (a medical doctor with specialized training in diagnosing, treating, and preventing infections caused by things like bacteria, viruses, fungi, and parasites) who monitors the use, the pattern of use as pertained to antimicrobial use. Aside from the ASP subcommittee meeting, the ASP team sets initiative toward proper usage of antibiotics. In addition to the established functions such as IV or by mouth conversion, dosing guidelines, renal dose adjustment, initiatives such as concurrent monitoring is established. Another example may be double-checking of drug of choice, dose and duration within 48 hours of antibiotic initiation thereby influencing the prescribing oof antibiotics. The ASP team gathers and monitors antibiotic prescribing and follow and report resistance patterns. The ASP monitors the hospital antibiotic use by analyzing the data on days of therapy per 1000 patient days. The ASP collects, analyzes and reports data to hospital leadership and prescribers. The ASP Team regularly informs staff on antibiotic prescribing and resistance information and recommended changes to improve results.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 42311 Based on interview and record review, the facility failed to ensure one of five sampled staff (Infection Preventionist [IP]) was qualified and competent in implementing the facilities infection control program by: 1. Failing to monitor Resident 16 for antibiotic (medication used to treat infection) use, side effects or adverse reaction (unintended pharmacologic effects that occur when a medication is administered correctly while a side effect is a secondary unwanted effect). 2. Failing to ensure Infection Control Surveillance Log (a documented record used to systematically track and analyze healthcare-associated infections and other infectious diseases within a healthcare facility) for Resident 19's antibiotics was completely filled in 3/2025. These failures had the potential to increase antibiotic resistance (don't respond to a drug) from unnecessary or inappropriate antibiotic use. Findings: a. During a review of Resident 16's Physician's Order dated 1/22/2024, the Physician's Order indicated the facility admitted Resident 16 on 1/22/2024, with diagnoses that included seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), traumatic brain injury (TBI- a disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head) from motor vehicle accident, and respiratory failure (occurs when the respiratory system cannot adequately provide oxygen to the body), with tracheostomy (a procedure to help air and oxygen reach the lungs by creating an opening into the trachea [windpipe] from outside the neck). During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) dated, 3/10/2025, the MDS indicated Resident 16 was on vegetative state (a condition where someone appears awake but lacks awareness of their surroundings, and they cannot engage in purposeful actions or communicate). The MDS indicated Resident 16 was dependent to staff for all activities of daily living (ADL- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 16 was always incontinent (unable to control) of bowel and bladder functions. During a review of Resident 16's Physician's Order, dated 3/13/2025, timed at 6:25 a.m., the Physician's Order indicated the following orders: 1. Zosyn (medication used to treat infection) 4.5 grams (gm- unit of measurement, used for medication dosage and/or amount) intravenous (IV- refers to the practice of administering fluids, medications, or other substances directly into a vein through a needle or tube) every six hours for seven days due to fever (a rise in body temperature, typically indicated by a reading of 100.4 F or higher). (continued on next page)

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Vancomycin (medication used to treat infection) IV, pharmacy to dose (physicians order a specific drug or drug class, and the pharmacist selects an appropriate dose for the individual patient). During a review of Resident 16's Nurses Notes from 3/13/2025 to 3/20/2025, the Nurses Notes indicated no documented monitoring for Zosyn and Vancomycin use and adverse reactions. During a review of Resident 16's Care plan on IV antibiotic treatment related to fever dated 3/14/2025, the Care Plan indicated an intervention to observe Resident 16 for any adverse reactions to antibiotic such as rash (a change in the appearance or feel of the skin, often appearing as redness, bumps, or itching), nausea, vomiting or gastrointestinal distress (encompasses a range of uncomfortable digestive symptoms like abdominal pain, bloating, gas, and changes in bowel habits). b. During a review of Resident 19's Admission/Registration Record, the Admission/Registration Record indicated the facility admitted Resident 19 on 2/12/2025, with diagnoses that included acute hypoxic respiratory failure (a serious condition where the lungs fail to adequately oxygenate the blood, leading to low oxygen levels in the bloodstream). During a review of Resident 19's Physician's Order dated 2/12/2025, the Physician's Order indicated Resident 19 had diagnoses that included acute hypoxic respiratory failure, tracheostomy and sepsis (a serious condition in which the body responds improperly to an infection). During a review of Resident 19's MDS dated , 2/19/2025, the MDS indicated Resident 19 was on vegetative state. The MDS indicated Resident 19 was dependent to staff for all ADL. The MDS indicated Resident 19 was on antibiotic. During a review of Resident 19's Physician's Order, dated 3/19/2025, the Physician's Order indicated the following for wound infection. 1. Cefepime (medication used to treat infection) 1 gram IV every 12 hours for 14 days. 2. Fluconazole (medication used to treat fungal [diseases caused by a yeast or mold] infection) 200 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) thru gastrointestinal tube (GT- a medical device used to deliver fluids, nutrients, or medications directly into the GI tract) daily for 14 days. During a review of facility's Infection Control Log, dated 3/2025, the Infection Control Log indicated Resident 19's date of admission, signs and symptoms, organism location and date infection resolved were left blank. During a concurrent interview, and record review on 4/11/2025, at 7:29 p.m., with the Minimum Data Set Nurse (MDSN), the facility's Infection Control Log dated 3/2025 was reviewed. The MDSN stated the facility's Infection Control Log was incomplete for Resident 19. During a concurrent interview and record review on 4/11/2025, with Registered Nurse (RN) 1, the facility's Infection Control Log, dated 3/2025, was reviewed. RN 1 stated the Infection Control Log had no date of admission for Resident 19 who had antibiotics. RN 1 stated the Infection Control Log also had missing entry on organism location and signs and symptoms for Resident 19. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555885	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherman Oaks Hospital Snf Dp	4929 Van Nuys Blvd Sherman Oaks, CA 91403

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/12/2025, at 10:11 a.m., with the Infection Preventionist (IP), the IP stated she (IP) started as an IP on 5/2024. The IP stated the Infection Control Log is the facility's Antibiotic Surveillance. The IP stated the antibiotic surveillance was not complete and had missing date of admissions, signs and symptoms, organism location and if infection was resolved. The IP stated Pharm 1 is in charge of the antibiotic surveillance and the nurses are in charge of completing the Infection Control Log. The IP stated the importance of monitoring use of antibiotic was to make sure it was the right medication for the organism detected. During an interview on 4/12/2025, at 10:37 a.m., with the IP, the IP stated she (IP) was informed on 1/2025, to create her (IP) own Infection Control Antibiotic Surveillance Log but as of 4/12/2025, she (IP) had not started it yet. The IP stated it was in her (IP)'s Job Description to do antibiotic surveillance and complete the infection control log, but she had not started on it. The IP stated the importance of antibiotic surveillance and completing the infection control log was to know the reason for the antibiotic use if it was the right antibiotic and if infection was resolved. The IP stated the monitoring of antibiotic use was documented by nurses every shift and she (IP) cannot do it alone. The IP stated she (IP) did not have time to check the nurse's documentation every shift for monitoring of antibiotic use. The IP stated she (IP) was the IP for General Acute Care Hospital 1 (GACH 1) and GACH 2 including the Skilled Nursing Facility 1 (SNF 1) and SNF 2. The IP stated the importance of monitoring for antibiotic use was to check if nurses had administered the antibiotic, checked laboratory result for antibiotic resistance and to find out if the chosen antibiotic was effective to treat residents' infection. During an interview on 4/13/2025, at 2:37 p.m., with the IP, the IP stated she (IP) was a member of the Association for Professionals in Infection Control and Epidemiology (APIC-provides evidence-based, scientific, and proven resources to infection preventionists, healthcare professionals, and patients) since 10/15/2024. The IP stated she had not attended the annual convention (a large, formal meeting that is held each year) and plans to join and attend in 6/2025. The IP stated it's her (IP) first time to attend in 6/2025. During a concurrent interview and record review on 4/13/2025, at 5:31 p.m., with the Director of Subacute (DSA), the IP's Job Description dated 4/2021 was reviewed. The IP's Job Description indicated, The Director of Infection Control supervises, assesses, plans, implements and evaluates the hospital surveillance, prevention/control of infection management. Infection Control Preventionist Director will conduct and or facilitate internal audits, reviewing supporting documentation, and appraise preparedness of the other infection prevention personnel in the hospital /department. Required to work close with colleagues in producing information analysis for retro, concurrent, and real time monitoring. Education, Experience, Training . 6. APIC membership and attendance. Duties and Responsibilities: 1. Conducts regular surveillance to determine the presence of infections. 2. Screens all patients and identifies those with active infection potential from the neonate through geriatric adults. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555885	A. Building B. Wing	04/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherman Oaks Hospital Snf Dp	4929 Van Nuys Blvd Sherman Oaks, CA 91403

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review all culture reports to identify cultures in which a specific pathogen has been isolated and makes appropriate recommendations. 4. Makes patient rounds on each unit to identify possible infectious processes and to evaluate previously institutes infection control measure. The DSA stated Infection Control log is part of the antibiotic surveillance. The DSA stated the IP should have monitored the use and effects of antibiotics. The DSA stated the importance of monitoring and tracking antibiotic use was to identify the pattern and determine the infection rate if increasing or trending (observing and analyzing changes in a patient's health status over time). The DSA stated the importance of the IP role was that the IP was in charge of prevention and control of infection and tracking of infection. The DSA stated the IP's Job description should have been updated to fit her qualification. The DSA stated the IP should have created her own tracking log for antibiotic use. During an interview on 4/13/2025 at 6:19 p.m., with the Chief Nursing Officer (CNO), the CNO stated the IP will attend the APIC convention this coming 6/2025. The ADM stated the IP is learning the process of the antibiotic surveillance. The ADM stated based on the IP's job description, the IP fell short on the qualifications to be the IP.