

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555885	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/04/2026
NAME OF PROVIDER OR SUPPLIER Sherman Oaks Hospital Snf Dp		STREET ADDRESS, CITY, STATE, ZIP CODE 4929 Van Nuys Blvd Sherman Oaks, CA 91403	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 (%) due to two (2) errors observed out of 26 total opportunities (error rate of 7.69 %) for two of six sampled residents (Resident 10 and Resident 2) observed during the Medication Administration Task by failing to:1)Ensure Registered Nurse (RN) 2 did not administer pantoprazole (Protonix - a proton pump inhibitor medication that reduces the amount of acid the stomach produces) to Resident 10, while the tube feeding was infusing during the 9 a.m. routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely) and not 30 minutes before a meal (Tube feeding constitutes a meal).2)Ensure RN 2 administered sucralfate (Carafate - a medication that coats and protects stomach ulcers so they can heal) to Resident 2 on an empty stomach and not while the tube feeding was infusing during the 12 p.m. routine medication pass. These failures had the potential to result in Resident 10 experiencing slower or incomplete healing of the gastrointestinal (GI) ulcer (a sore or open wound in the lining of the stomach and first part of the small intestine) symptoms and Resident 2 experiencing reflux of acid contents due to reduced effectiveness. Findings:a.During a review of Resident 10's admission Record (AR), the AR indicated the resident had a service date of 4/6/2026.During a review of Resident 10's Minimum Data Set (MDS-a resident assessment tool), dated 3/5/2026, the MDS indicated that the facility originally admitted the resident on 2/24/2015 and readmitted on [DATE]. The MDS indicated the resident used a feeding tube while a resident of the facility. The MDS indicated the resident sometimes makes self-understood and usually understand others. During a review of Resident 10's History and Physical (H&P), dated 4/27/2026, the H&P indicated the resident had gastric ulcers and duodenal ulcers, with acute (sudden) blood loss anemia (a condition where the body does not have enough healthy red blood cells) secondary to GI bleed and status post transfusions (a medical procedure where blood or blood components from a donor are given to patient through a vein).During a review of Resident 10's Physician's Orders, the Physician's Orders indicated Resident 10's diagnoses including chronic respiratory failure (a long-term condition in which not enough oxygen passes from the lungs into the blood), tracheostomy (a surgical hole in the front of the neck into the windpipe, with a tube inserted to help the person breathe), and ventilator dependent (a patient relies on a breathing machine to do most or all of their breathing because their lungs, muscles, or brain can no longer manage it adequately on their own). The Physician's Order, dated 4/6/2026, indicated pantoprazole sodium 40 milligrams (mg - a unit of measurement) granule packet, mix one (1) packet with apple juice or apple sauce and give via GT twice daily for 60 days.During an observation on 6/3/2026 at 9:53 a.m. with RN 2, inside Resident 10's room, the tube feeding was observed connected to the resident infusing the feeding at a rate at 65 ml/hr. and delivered 350 ml. RN 2 paused the tube feeding machine. RN 2 was observed administering (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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pantoprazole to Resident 2 via the feeding tube. RN 2 resumed the tube feeding at 65ml/hr. During a concurrent observation and interview on 6/3/2026 at 10:19 a.m. with RN 2, RN 2 stated Resident 10 is on continuous tube feeding with feeding delivered of 350 ml. During a concurrent interview and record review on 6/4/2026 at 11:45 a.m. with RN 1, the Manufacturer (MF) 1's Instructions for Use for pantoprazole, revised 7/2022 were reviewed. The Manufacturer's Instructions indicated to take pantoprazole about 30 minutes before a meal. RN 1 stated pantoprazole is usually scheduled at 6AM on an empty stomach because tube feeding starts at 7AM. RN 1 stated Protonix reduces the acid in the stomach and relieves symptoms such as heartburn, difficulty swallowing, and coughing. It helps heal acid damage on the stomach and esophagus and helps prevent ulcers and may help prevent cancer of the esophagus. RN 1 stated that the medication should be administered 30 minutes before a meal and that tube feeding constitutes a meal. RN 1 stated that administering the medication with tube feeding could impair absorption and decrease its therapeutic effectiveness. RN 1 further stated that, given Resident 10's history of gastric ulcers, failure to receive that intended therapeutic benefit placed the resident at risk for heartburn, exacerbation of ulcer-related symptoms, and gastrointestinal bleeding. During an interview on 6/4/2026 at 2:57 p.m. with the Director of Nursing (DON), the DON stated the physician was called to clarify how the medication was to be given to Resident 10, because the order did not have specific details. During a review of the facility's policy and procedures (P&P) titled, Enteral Feeding, last approved by the Governing Board 2/2026, the P&P indicated specific drug interactions with enteral feedings including: Hold enteral feedings for one hour before and after a PPI (e.g. Protonix, Prevacid, etc.) dose. b. During a review of Resident 2's AR, the AR indicated the resident had a service date of 1/1/2026. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the facility admitted the resident on 2/12/2025. The MDS indicated the resident was comatose (persistent vegetative state/no discernible consciousness). The MDS indicated the resident received feeding tube while a resident of the facility. During a review of Resident 2's Physician's Orders, dated 8/29/2025, the Physician's Orders indicated to administer sucralfate 1 gram (g - a unit of measurement) per 10 milliliters (ml - a unit of measurement) oral suspension, give 10 ml (1 g) via gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube (GT) every six (6) hours for gastroesophageal reflux disease (GERD - a condition in which the stomach contents move up into the esophagus). During a review of Resident 2's H&P, dated 1/1/2026, the H&P indicated the resident was unable to provide any history and remained on mechanical ventilation (a medical device to help support or replace breathing). During an observation on 6/3/2026 at 11:55 a.m., inside Resident 2's room, the tube feeding was observed connected to the resident with feeding rate at 65 ml/hr. and delivered 410 ml. RN 2 paused the tube feeding machine. RN 2 was observed administering sucralfate 1 g, 10 ml, to Resident 2 via the feeding tube. RN 2 resumed the tube feeding at 65 ml/hr. During a concurrent observation and interview on 6/1/2026 at 12:04 p.m. with RN 2, RN 2 stated she paused the tube feeding machine to administer the medications and resumed the tube feeding. RN 2 stated sucralfate is usually given on an empty stomach, and she does not know why there is no order to give on an empty stomach. RN 2 stated she would call the pharmacist to ask for recommendations. During a concurrent interview and record review on 6/4/2026 at 11:45 a.m. with RN 1, Carafate Food and Drug Administration (FDA- is the United States government agency that regulates the safety of food, medicines, vaccines, and medical devices) information, dated 7/2017 was reviewed. RN 1 stated that the information indicated that it should be given on an empty stomach at least an hour before taking it. RN 1 stated Resident 2's Carafate is scheduled every 6 hrs. at 6AM, 12PM, 6PM, and 12AM. RN 1 stated she can ask the doctor how to give the Carafate and ask for (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specific instructions. RN 1 stated Carafate is given for ulcers and protects the gastrointestinal tract from the acidic environment. RN 1 stated that when Carafate is not given on an empty stomach there may be food in the stomach and it would not be able to coat the barrier in the stomach. RN 1 stated Resident 2's ulcer will not heal and if they have an active ulcer then a GI bleed can recur. During an interview on 6/4/2026 at 2:54 p.m. with the Director of Nursing (DON), the DON stated that for Carafate the licensed nurses need to call the doctor and have the doctor evaluate if the medication is still necessary. The DON stated the licensed nurse should have notified the doctor as soon as they could. The MD was called today, 6/4/2026. During a review of the facility's P&P titled, Physician's Orders, last approved by the Governing Board on 2/2026, the P&P indicated that prescribing medications should be legibly printed in black ink and same for electronic orders, and must include: directions for use, and frequency of administration. The P&P indicated Challenging or Disputing a Physician's Order 1. When an order is being disputed, the healthcare team member shall expeditiously contact the physician who wrote the order, seeking further clarification and supporting documentation, if necessary . 4. Any changes or clarifications in the order should be written in the chart.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual resident needs when residents receiving a pureed diet (foods that are soft, pudding like consistency and hold its shape), were served pureed smothered rice pilaf, herb baked cod, and carrots with a thin, watery consistency. The food items spread into one over the another appearing to merge on the plate rather than maintaining a cohesive, pudding like consistency. This failure had the potential to result in difficulty in swallowing, difficulty in eating, decrease in food and nutrient intake, resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a record review of Resident 13's admission Record, the admission Record indicated Resident was admitted on [DATE] with diagnoses including stroke (a medical emergency that occurs when blood flow to the brain is interrupted, causing brain cells to die), and traumatic brain dysfunction (when physical force disrupts normal brain function). During a record review of Resident 13's Minimum Data Set (MDS-a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 13's cognition functioning (the ability to think, learn, remember, use judgment and make decisions) was intact. The MDS indicated Resident 13 was dependent on staff for eating, oral hygiene, bathing, and personal hygiene. During a record review of Resident 13's Physician Orders, dated 6/10/2024, the physician orders indicated an order for puree diet with thin liquids. During a record review of the facility's lunch menu, dated 6/2/2026, the menu indicated residents on puree diet would include the following foods on the plate 1/3 cup of rice pilaf, 4oz cod fillets and 1/4 cup of carrots. During an observation and interview with Food Services Director (FSD) on 6/2/2026 at 11:50 a.m., observed staff plating meal tray for the food items in one dinner plate. When food items poured together, they were observed to run into one another, appearing to merge rather than remain distinct as individual pureed portions. A spoon tilt test was performed, which demonstrated that the food did not hold its shape on the spoon and flowed easily, indicating a consistency thinner than expected for pureed diet. The FSD stated the consistency of the pureed food items was not appropriate. The FSD stated that pureed foods should maintain an applesauce-like consistency, holding their shape on a spoon and remaining separate on the plate. During an interview with the Director of Nurses (DON) on 6/4/2026 at 3:30 p.m., the DON stated that the puree diet consistency should not be watery, and it should maintain an applesauce like consistency and the food should hold their shape. The DON stated, the facility needs to follow the appropriate dietary guidelines. ^ During a record review of the facility's policy and procedure, titled, Food and Nutrition Services, dated February 2026, the policy and procedure indicated pureed diet is composed of regular foods that are blenderized or have a natural pudding like texture, such as ice cream, Jello, mashed potatoes and baby food. Pureed diet is designed to minimize the amount of chewing required and increase the ease of swallowing food.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure physician orders were implemented and documented for repositioning Resident 7 every two hours. This deficient practice had the potential to result in the resident not being repositioned as ordered, which could lead to development or worsening of pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence), and skin breakdown. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including respiratory failure (a syndrome in which the respiratory system fails), traumatic brain injury (a disruption in normal brain function caused by an outside physical force), persistent vegetative state (a condition where severe brain damage leaves an individual in a state of wakeful unawareness), and seizure disorder (a chronic neurological condition characterized by recurrent, unprovoked seizures). During a review of Resident 7's Physician Orders dated 1/22/2024, the physician orders indicated turn and reposition the resident every two hours while in bed and provide routine skin care every two hours with turning. During a review of Resident 7's Plan of care dated 12/29/2025, the care plan indicated that Resident 7 was incontinent of bowel and will not develop perineal rashes. The interventions included checking for wetness and soiling every two hours. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 7's cognitive status (the ability to think, learn, remember, use judgment and make decisions) was severely impaired. The MDS indicated Resident 7 was dependent on staff for oral hygiene, toileting hygiene, bathing, and personal hygiene. During an interview with Registered Nurse (RN 1) on 6/2/2026 at 9:08 a.m., RN 1 stated, Certified Nursing Assistant and Nurses (Licensed Vocational Nurses and Registered Nurses) are responsible for checking Residents for wetness every two hours. RN 1 stated, there is no documentation of staff checking for wetness every two hours. RN 1 stated if the resident is not assessed for wetness, it can increase the risk of skin breakdown. During an interview with the Director of Nursing (DON) on 6/4/2026 at 4:15 p.m., the DON stated, the facility documents repositioning of Residents once per shift and not every two hours as ordered by the physician. The DON stated it is important to document every two hours of repositioning as ordered by the physician to prevent any risks of skin breakdown. A review of the facility's policy and procedure titled, Charting Guidelines dated February 2022, indicated it is the policy of the facility that all documentation will be completed as required for each resident. 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. All charting should be done as soon as possible after a given event. Document normal findings as well as abnormal findings as this shows that the resident was being assessed.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide an ongoing program of activities designed to meet the interests and preferences of one of three sampled residents (Resident 13). This deficient practice had the potential to place Resident 13 at risk for decreased engagement, stimulation, and psychosocial well-being. Findings: During a review of Resident 13's admission Record, the admission Record indicated Resident 13 was admitted to the facility on [DATE] with diagnoses that included a stroke (a medical emergency that occurs when blood flow to the brain is interrupted, causing brain cells to die), and traumatic brain dysfunction (when physical force disrupts normal brain function). During a record review of Resident 13's Minimum Data Set (MDS-a resident assessment tool), dated 3/3/2026, the MDS indicated Resident 13's cognitive functioning status (the ability to think, learn, remember, use judgment and make decisions) was intact. The MDS indicated Resident 13 was dependent on staff for eating, oral hygiene, bathing, and personal hygiene. During an observation and interview, while in the activities room on 6/1/2026 at 9:00 a.m., Resident 13 was observed watching television and stated he would like more books and hands-on activities. The Activities Director (AD) stated Resident 13 liked to use an iPad, but she does not let him use it because right now they are watching T.V. The AD stated, Resident 13 liked books and presented two children's books as available activity materials. During a concurrent interview and record review of the monthly activity calendar with the AD on 6/4/2026 at 2:10 p.m., the AD identified aromatherapy as a scheduled activity offered on Wednesdays. The AD stated that the facility ran out of aromatherapy and no replacement activity had been arranged. During an interview with the Director of Nurses (DON) on 6/4/2026 at 3:30 p.m., the DON stated she will provide an in-service to the AD regarding Resident centered activities. The DON stated, if they could not provide aromatherapy, another activity should have been implemented. The DON stated the failure to provide Residents with individualized activities can result in a decline in social, physical and emotional functioning. A review of the facility's policy and procedure titled, Activities Program Requirements reviewed on 2/26/2026, indicated Residents should be encouraged to participate in activities planned to meet their individual needs. A written, planned schedule of social and other purposeful individual and group activities shall be designed with its purpose to enable each resident to maintain the highest attainable social, physical and emotional functioning.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of a significant change of condition for one of three sampled Resident (Resident 7). This deficient practice had the potential to result in delayed medical evaluation, treatment and intervention, placing Resident 7 at risk of worsening conditions and adverse health outcomes. Findings: During a review of Resident 7's admission Record, the admission Record indicated Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE] with diagnoses including respiratory failure (a syndrome in which the respiratory system fails), traumatic brain injury (a disruption in normal brain function caused by an outside physical force), persistent vegetative state (a condition where severe brain damage leaves an individual in a state of wakeful unawareness), and seizure disorder (a chronic neurological condition characterized by recurrent, unprovoked seizures). During a review of Resident 7's care plan dated 12/29/2025, the care plan indicated that the resident was unable to provide own nutritional needs due to disease process. Interventions included to monitor weight carefully as ordered and to report to Medical Doctor if weigh loss or weight gain of five pounds per month. Five percent or more in 30 days or 10% in last 180 days. During a review of Resident 7's Minimum Data Set (MDS-a resident assessment tool), dated 3/9/2026, the MDS indicated Resident 7's cognitive status (the ability to think, learn, remember, use judgment and make decisions) was severely impaired. The MDS indicated Resident 7 was dependent on staff for oral hygiene, toileting hygiene, bathing, and personal hygiene. During a review of Resident 7's Weight Chart dated 1/2/2026 to 5/7/2026 indicated 8.23% weight loss: 1/2/2026 - 158lbs 2/11/2026 - 155lbs 3/4/2026 - 149 lbs. 4/2/2026 - 148 lbs. 5/5/2026 - 154 lbs. 5/7/2026 - 145 lbs. During a review of the Dietician's Progress Notes dated 3/13/2026 indicated Resident 7's weight was 149 pounds. The Dietician recommended to continue tube feeding of TwoCal HN @ 45ml/hour. No other changes were recommended. A record review of the Dietician's Progress Notes dated 4/13/2026 indicated Resident 7's weight was 148 pounds with no change recommended. During a review of the Dietician Progress notes dated 5/14/2026, indicated Resident 7's weight was 145 pounds. Recommendations from the dietitian indicated to continue the tube feeding TwoCal HN @ 50 ml/hour for 20 hours. No other changes. During an interview with Registered Nurse (RN 1) on 6/2/2026 at 8:11 a.m., RN1 stated, the Dietician did not address Resident 7's weight on 5/7/2026 of 145 pounds in the Interdisciplinary Meeting. RN 1 stated, there is no documentation addressing Resident 7's weight loss and the reason for reweighing Resident 7 on 5/7/2026. RN 1 stated, there is no documentation of the significant weight loss to the physician. RN 1 stated, it is important to address the weight loss to the physician and the dietician to prevent any further weight loss. During an interview with the Director of Nurses (DON) on 6/4/2026 at 4:10 p.m., the DON stated, she would notify Resident 7's physician immediately regarding the weight loss. The DON further stated that physician notification is important to obtain new orders and interventions to prevent further weight loss. During a review of the facility's policy and procedure titled, Change in Resident Condition/Notification of Changes dated February 2026 indicated it is the policy of the facility that all changes in resident condition and other changes, as required by regulations, will be communicated to the physician and family or legal representative.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review, the facility failed to provide acceptable parameters of nutrition for one of one sampled resident (Resident 3) reviewed under nutrition care area when the facility failed to follow through with the Registered Dietitian (RD)'s recommendation to check Resident 3's hemoglobin A1C (HgA1C - a blood test that measures the average blood sugar levels over the past two [2] to three [3] months). This deficient practice had the potential to result in Resident 3 losing weight. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the resident had a service date of 1/1/2026. During a review of Resident 3's Minimum Data Set (MDS-a resident assessment tool), dated 5/5/2026, the MDS indicated the facility admitted the resident on 7/25/2024. The MDS indicated that the resident rarely/never makes themselves self-understood and rarely/never understands others. The MDS indicated that Resident 3 has severely impaired cognitive skills for daily decision making. The MDS indicated that the resident required and used a feeding tube while a resident of the facility. During a review of Resident 3's Care Plan (CP) dated 12/30/2025 and titled, At risk for nutritional deficit due to tube feeding (TF- are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]), the CP indicated the resident goal to minimize significant weight change with interventions including an RD consult as ordered. During a concurrent interview and record review on 6/2/2026 at 8:58 a.m. with the MDS Coordinator (MDSC), Resident 3's clinical record indicated the following:- Nutrition Assessment, dated 1/16/2026, indicated weight status 124 pounds (lbs.-a unit of measurement); -7 lbs. weight change. Weight loss of 5.3 per hundred (%- a unit of measurement) in 3 months; Recommend monitoring blood glucose and A1C due to patient has a history of diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with expected outcomes/goal included prevent further weight loss; weight stabilization.- Nutrition Assessment, dated 2/17/2026, indicated weight status 123 lbs.; -1 lb. weight change. Weight loss of 7% in 3 months; Recommend monitoring blood glucose and A1C since patient has a history of DM. Expected outcome/goal included prevent further weight loss; weight stabilization.- Reviewed Nurses Notes from 1/15/2026 to 3/5/2026 with the MDSC, the MDSC stated there was no documentation about the RD's recommendation for HgbA1C. The MDSC stated that hemoglobin A1C was last completed on 10/4/2024 and no other records were found after 10/4/2024. During an interview on 6/4/2026 at 12:06 p.m. with Registered Nurse (RN) 1, RN 1 stated that the RD's recommendation should be communicated to the doctor during the day to address the resident's weight loss and be documented in the resident's clinical chart. RN 1 stated when it is not documented then it was not done. RN 1 stated when it is not done the resident could potentially lose more weight. During an interview on 6/4/2026 at 3:01 p.m. with the Director of Nursing (DON), the DON stated the RD notifies the charge nurse when there is a recommendation whether they call or discussed during the interdisciplinary team meeting. The DON stated she would need to clarify with the RD about what she wants the nursing staff to do. The DON stated the RD's recommendation is to establish the resident's nutritional status for the resident and based on that then she can notify the charge nurse for that recommendation. The DON stated if there is lack of oversight then there is a potential that they are not going to meet the nutritional needs of the resident. During a review of the facility's policy and procedure (P&P) titled, Subacute Nutrition Therapy Assessment and Reassessment, last approved by the Governing Board on 2/2026, the P&P indicated that the purpose of this policy is To evaluate and monitor the nutritional status of a patient, enabling the identification of a patient who is malnourished or at risk of developing malnutrition, and providing goals for medical (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nutrition therapy. 5. RD recommendations for lab levels, changes in tube feeding rate and/or formula, addition and subtraction of nutritional supplements, alteration of patient weighing schedule, or other recommendations shall be followed and documented within one week of initial written request.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure staff providing care and services to a resident who had a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) utilized facility protocols regarding feeding tube nutrition and care for one of one sampled resident (Resident 2) reviewed for tube feeding care area by failing to ensure Resident 2's head of bed was elevated at 35 to 45 degrees at all times while receiving tube feeding. This deficient practice had the potential to result in increased risk of aspiration (breathing food, liquid, saliva, or stomach contents into the airway and lungs rather than swallowing) and respiratory symptoms such as cough, and pneumonia (an infection/inflammation in the lungs). Findings: During a review of Resident 2's admission Record (AR), the AR indicated the resident had a service date of 1/1/2026. During a review of Resident 2's History and Physical (H&P), dated 1/1/2026, the H&P indicated the resident was unable to provide any history and remained on mechanical ventilation (a medical device to help support or replace breathing). During a review of Resident 2's Minimum Data Set (MDS-a resident assessment tool), dated 5/19/2026, the MDS indicated the facility admitted the resident on 2/12/2025. The MDS indicated the resident was comatose (persistent vegetative state/no discernible consciousness). The MDS indicated the resident received feeding tube while a resident of the facility. During a review of Resident 2's Physician's Orders, the Physician Orders indicated the following: - dated 5/28/2026, the resident with diagnoses including acute hypoxic respiratory failure (sudden low blood oxygen from lung failure), status-post cardiopulmonary arrest (after the heart and breathing stopped), tracheostomy (a medical procedure that creates the opening in the front of the neck into the windpipe), and sepsis (a life-threatening blood infection). - dated 2/12/2025, elevate head of bed 35 to 45 degrees at all times while feeding is administered and for one hour after feeding if bolus (a method of tube feeding where a specific, measured amount of liquid nutrition is delivered into the stomach multiple times a day) or intermittent (a method of providing liquid nutrition through a feeding tube on a strict schedule, rather than continuously). During a review of Resident 2's Care Plan (CP) titled At risk for aspiration due to TF, dated 12/30/2025, the CP indicated the resident with goal of not exhibiting any signs and symptoms of aspiration with interventions including elevate head of bed. During an observation on 6/1/2026 at 11:20 a.m., inside Resident 2's room, Resident 2 was observed lying on his right side while in bed. Tube feeding formula titled Glucerna with Carbsteady 1.2 cal, dated 6/1/2026, was observed infusing at a rate of 65 milliliters (ml - a unit of measurement) per hour with a total of 256 ml delivered at the time of observation. Observed Resident 2's head of bed elevated at 25 degrees. During a concurrent observation and interview on 6/1/2026 at 1:11 p.m. with Registered Nurse (RN) 1, inside Resident 2's room, Resident 2 was observed lying on his right side while in bed. RN 1 stated that Resident 2's head of bed is positioned at 25 degrees while receiving tube feeding at rate of 65 ml/hr. RN 1 stated Resident 2's head of bed should have been elevated at 35 to 45 degrees to prevent aspiration. RN 1 stated Resident 2's head of bed at 25 degrees while receiving TF placed the resident as risk to develop aspiration pneumonia and respiratory issues such as coughing. During an interview on 6/4/2026 at 12 p.m. with RN 1, RN 1 stated that a care plan is a guide for them on how to care for the resident based on the problems that are identified including interventions that need to be done. RN 1 stated that after Certified Nursing Assistant (CNA) provided a bath or positioned the resident, the charge nurse, the medication nurse, and CNAs are responsible to ensure that the head of bed is (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	elevated. RN 1 stated this intervention was not implemented for Resident 2. RN 1 stated that when the feeding is ongoing the resident can aspirate on their feeding and exhibit respiratory symptoms such as coughing and can potentially lead to pneumonia. During an interview on 6/4/2026 at 2:54 p.m. with the Director of Nursing (DON), the DON stated the staff should follow the physician's order. The DON stated the head of bed needs to be at 35 degrees to prevent aspiration for Resident 2. During a follow up interview on 6/4/2026 at 2:59 p.m. with the DON, the DON stated the care plan is used when they have identified an issue that needs to be resolved and maintenance for preventative measures that are working. The DON stated this is to communicate to the staff what they are doing for the residents. During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding, last approved by the Governing Board 2/2026, the P&P indicated that the purpose of this P&P is To provide complete or supplemental nutrition via the gastrointestinal tract. Keep head of bed elevated 30-45 degrees during feedings to facilitate emptying stomach and prevent aspiration.		