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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYCE EISENBERG KEEFER MEDICAL CENTER D/P SNF	7150 TAMPA AVENUE , RESEDA, California, 91335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The following reflects the findings of the Department of Public Health during the Recertification Survey and investigation of a facility reported incident FRI). The Recertification Survey was conducted from 3/9/2026-3/12/2026 The resident census at the time of the survey was 233 Highest Severity and Scope: E No deficiency was issued for FRI Number 2802916.	F0000		04/11/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to:	F0552	Joyce Eisenberg - Keefer Medical Center makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. Joyce Eisenberg - Keefer Medical Center is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes Joyce Eisenberg - Keefer Medical Center's written credible allegation of compliance for the deficiencies noted. F-552 Corrective Action for Affected Residents: The Director of Nursing (DON) met with LVN involved to provide 1:1 education regarding requirement. LVN reviewed Resident 59's current medication regimen and ensured that Resident 59 received information regarding the name of each medication, its indication, and the right to refuse medications and resident confirmed she is aware of medications as above. RN Unit Manager completed a comprehensive review of Resident 101's bed rail use and obtained informed consent from Resident 101, including explanation of the reason for bed rail use, risks, benefits, and alternatives. The DON or designee ensured that the Informed Consent for Bed Rail Use form was completed	04/11/2026

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Sumbitted by ePOC	on 4/2/2026

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F0552 SS = D	Continued from page 1 a. Ensure to provide the name of the medication and its indication (reason for the use of the medication) prior to administration of the medication for one of four (Resident 59) residents observed for medication administration. This deficient practice violated Resident 59's rights to make decisions regarding her medication regimen. b. Obtain informed consent for the use of bed siderails for one of two (Resident 101) residents reviewed for restraints. This deficient practice violated Resident 101's right to be informed of and participate in the resident's treatment. Findings: a. During a review of Resident 59's Admission Record (AR), the AR indicated the facility originally admitted the resident on 06/02/2022 and readmitted on 03/25/2024 with diagnoses including chronic respiratory failure (can occur when your blood has too much carbon dioxide or not enough oxygen) and age-related osteoporosis (bones lose their ability to regrow and reform themselves). During a review of Resident 59's Minimum Data Set (MDS-a standardized assessment and care screening tool) dated 12/12/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact. The MDS indicated that Resident 59 required partial/moderate (helper does less than half the effort) assistance for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During a concurrent observation and interview on 3/11/2026 at 4:43 p.m., with Licensed Vocational Nurse 5 (LVN 5), observed LVN 5 administering midodrine (a medication used to treat low blood pressure) 5 milligrams (mg-unit of measurement), Senokot-S (a medication used to treat constipation [infrequent and	F0552	Continued from page 1 with appropriate signatures including Resident 101 and the licensed nurse verifying that consent was obtained. 3/17/26 Identifying other Residents having the Potential to be Affected: As most residents have medications, DON or designee provided education to licensed nurses on the requirement to provide information regarding the name of each medication, its indication, and the right to refuse medications as applicable. DON educated residents during the 3/19/26 Resident Council meeting regarding their right to be informed on their medications. The Medical Records Manager conducted an audit of other residents currently utilizing bed rails. The RN Unit Managers reviewed the Informed Consent for Bed Rail Use forms to ensure that informed consent was obtained, forms are completed in their entirety including resident or resident representative signature, reason for use, and licensed nurse signature. For residents with incomplete consent forms, the RN Unit Managers or designee obtained proper informed consent including explanation of risks, benefits, and alternatives. Measures put into place or Systemic Changes: The DON or designee in-serviced LVNs and RNs on the requirement to inform residents of medication names and indications prior to administration, the resident's right to be informed of and participate in treatment decisions, and the resident's right to refuse medications. The in-service included review of the facility's Administrative Manual regarding resident rights to make decisions about medical treatment and to accept or refuse proposed treatment. The DON or designee in-serviced LVNs and RNs on the facility's Bed Rails policy and procedure, including the requirement to obtain informed consent prior to bed rail installation, proper completion of the Informed Consent for Bed Rail Use form including resident or resident representative signature, documentation of the reason for bed rail use, explanation of risks, benefits, and alternatives, and licensed nurse signature verifying consent was obtained. Plan to Monitor Performance: RN Unit Manager or designee will begin conducting medication administration observations for a sample of residents with intact cognitive skills for daily decision making. The observations will verify that nursing staff inform residents of medication names and indications prior to administration. These observations will be conducted weekly for four weeks, then monthly for three months.	

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F0552 SS = D	Continued from page 2 difficult bowel movements]) 8.6 mg, Trelegy Ellipta (an inhaler used to treat chronic obstructive pulmonary disease [COPD-an ongoing lung condition caused by damage to the lungs]) 200-62.5-25 micrograms (mcg-unit of measurement), Miralax (medication used to treat constipation) 17 grams (gm-unit of measurement), and Tylenol (a medication used to relive pain) 325 mg orally to Resident 59, followed by administering Systane (a medication used to lubricate [to hydrate, soothe, and protect the surface of the eyes]) to both eyes. Resident 59 was not observed informing Resident 59 of the name of each medication and its indication during administration of the medications. When LVN 5 was asked why she did not inform the resident of the names of the medications and their indication, LVN 5 stated she was not aware that it was required per facility policy. During an interview on 3/12/2026 at 09:08 a.m., with the Director of Nursing (DON), the DON stated that residents have the right to be informed about their care including their medications. The DON stated not providing information about their medication regimen restricts Resident 59 from exercising this right. During a review of the facility`s “Administrative Manual,” last reviewed on 04/16/2025, the administrative manual indicted that “the resident has the right to: Make decisions about his/her medical condition Accept or refuse the proposed treatment…” b. During a review of Resident 101's Face Sheet, the Face Sheet indicated the facility originally admitted the resident on 11/17/2025 and readmitted on 12/18/2025 with diagnoses including hypertension (high blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 101's MDS dated 02/20/2026, the MDS indicated the resident's cognitive skills for daily decision making was intact. The MDS indicated that Resident 101 required partial/moderate (helper does less than half the effort) assistance for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting).	F0552	Continued from page 2 Medical Records department will begin auditing Informed Consent for Bed Rail Use forms for residents utilizing bed rails to ensure forms are completed in their entirety including resident or resident representative signature, reason for bed rail use, and licensed nurse signature. The audits will be conducted weekly. The “Stand Up Meeting Routine Questionnaire” form was updated to include verification of consent for bed rails. Medical Records Manager or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0552 SS = D	Continued from page 3 During a concurrent interview and record review on 3/12/2026 at 09:08 a.m., with the DON, reviewed Resident 101's "Informed Consent for Bed Rail Use, dated 11/19/2026. The DON stated that the consent was not completed as it did not include the signature of Resident 101 or the resident's representative, the reason for the use of side rails, or the licensed nurse's signature indicating that the consent was obtained and verified. The DON stated that the resident's rights were not protected as consent was not obtained and no explanation was provided regarding the reason for the use of side rails. During a review of the facility`s policy and procedures (P&P) titled "Bed Rails," last reviewed on 04/16/2026, the P&P indicated that if the IDT determines that bed rails are appropriate, they will use the "Informed Consent for Bed Rail Use form prior to installation. The information will be presented to the resident, or if applicable, the resident representative, in a manner that is understood and that consent is given voluntarily, free form coercion…".	F0552		
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a call light (a device used by a patient to signal his or her need for assistance from a professional staff) was within reach for one of one sampled resident (Resident 72) investigated during a random observation. This deficient practice had the potential to result in Resident 72 not being able to call for facility staff assistance and delay in the provision of necessary care and services which could negatively affect the residents' comfort and well-being. Findings: During a review of Resident 72's Face Sheet, the Face	F0558	F-558 Corrective Action for Affected Residents: On 3/10/2026, Certified Nursing Assistant (CNA 1) immediately placed Resident 72's call light within reach. Identifying other Residents having the Potential to be Affected: RN Unit Managers conducted facility-wide room checks of current residents to ensure that call lights were within reach and accessible to residents based on their individual needs and preferences. Out of 62 residents with limited mobility while in their room, 3 were found to not have the call light within reach. Any residents found with call lights out of reach had immediate corrective action taken to place call lights within reach by education to the responsible nurse 3/31/26. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced Licensed nurses and Certified Nursing Assistants on the facility policy and procedure titled "Answering the Call Light," with emphasis on ensuring call lights remain within reach and accessible to residents at all times, including when residents are repositioned, moved to wheelchairs, or transitioned between locations. The in-service included education on assessing individual resident needs and preferences for call light placement based on physical limitations, mobility status, and cognitive abilities. Attendance records and lesson	04/11/2026

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F0558 SS = D	Continued from page 4 Sheet indicated the facility admitted the resident on 2/17/2026 with diagnoses including unspecified severe sepsis (a life-threatening blood infection) and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident /72's /History and Physical (H&P) dated 12/10/2025, the H&P /indicated /Resident /72 /speaks in full sentences, was able to make her /own needs known and able to make simple medical decisions. During a review of Resident 72's Minimum Data Set (MDS - an assessment and care screening tool) dated 2/13/2026, the MDS indicated Resident 72 usually makes herself understood and usually understands others. The MDS further indicated Resident 72 needs substantial assistance (helper does more than half the work) with upper body and lower dressing, personal hygiene and putting on and taking off shoes. During an observation on 3/10/2026 at 9:51 a.m. in Resident 72's room, Resident 72 was up in the wheelchair with a bedside table in front of him halfway between his bed and the entrance door. Resident 72 lifted up his empty cup and made a gesture of wanting more. Resident 72's call light located on the bed, was out of his reach. During a concurrent observation and interview on 3/10/2026 at 9:57 a.m. inside Resident 72's room with Certified Nursing Assistant (CNA 1), CNA 1 stated she forgot to place the call light next to Resident 72. CNA 1 stated the call light should be next to Resident 72 to ensure he can communicate with facility staff, including making requests for water. During an interview on 3/13/2026 at 2:15 p.m., with the Director of Nursing (DON), the DON stated all call lights should be within each resident's reach so staff would be able to attend to their needs timely at all times. During a review of the facility's policy and procedure (P&P) titled, "Answering the Call Light," last reviewed 4/16/2025, the P&P indicated staff must answer timely to the resident's request and needs. The P&P further	F0558	Continued from page 4 plans were maintained. Plan to Monitor Performance: Beginning 4/6/2026, the RN Unit Manager or designee will conduct random room audits of a minimum of 5 rooms per floor per week for four consecutive weeks, to verify that call lights are within reach and accessible to residents based on their individual needs and positioning. If deficiencies are identified during audits, immediate corrective action will be taken and the responsible staff member will receive re-education and supervisory intervention as appropriate. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0558 SS = D	Continued from page 5 indicated staff must ensure the call light is accessible to the resident.	F0558		
F0577 SS = E	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to notify residents of the existence and the location of the results of the most recent standard survey (means the Statement of Deficiencies Form CMS-2567) for ten (Resident 189, Resident 30, Resident 51, Resident 59, Resident 62, Resident 65, Resident 83, Resident 203, Resident 219, and Resident 236) of 11 sampled residents in the resident council. This deficient practice had the potential for residents and their representative to not know how the facility	F0577	F-577 Corrective Action for Affected Residents: The Administrator or designee met with Resident 189, Resident 30, Resident 51, Resident 59, Resident 62, Resident 65, Resident 83, Resident 203, Resident 219, and Resident 2, during resident council or individually to inform them of the existence of the most recent survey results, the location of the survey results binder on each floor near the dining room entrance and next to the consumer board in JEK 1, and their right to review these results at any time. The Administrator or designee provided each resident with written information documenting the location of the survey results on their respective floors. Identifying other Residents having the Potential to be Affected: The Administrator or designee met with residents during resident council meeting on 3/19/26 and informed them of the existence and location of the most recent survey results. The Director of Activities made announcements in all main dining rooms to inform them of the existence of the survey results dated, the location of the survey results binder on their floor, and their right to review the results. Measures put into place or Systemic Changes: The Administrator or designee will notify residents of the existence and location of survey results during the during resident council meetings at least quarterly. The Activities Director (AD) or designee added a standing agenda item to resident council meetings to inform residents of the existence and location of survey results, ensuring this information is communicated at least quarterly. The AD or designee will document this notification in the resident council meeting minutes. Plan to Monitor Performance: Beginning 4/6/26, Director of Activities or designee will ask residents during resident council and during randomly to verify they are aware of location and existence of survey findings. The Director of Activities or designee will report audit results, including any identified deficiencies and corrective actions taken, to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	04/11/2026

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F0577 SS = E	Continued from page 6 is performing regarding resident care. Findings: a. During a review of Resident 189's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on 2/01/2024, with diagnoses that included hypertension (high blood pressure). During a review of Resident 189's Minimum Data Set (MDS, a resident assessment tool), dated 2/11/2026, the MDS indicated Resident 189 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. b. During a review of Resident 30's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 7/13/2023, with diagnoses that included osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 30's MDS, dated 1/23/2026, the MDS indicated Resident 30 was cognitively intact with skills required for daily decision making. c. During a review of Resident 51's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 11/15/2023 with diagnoses that included generalized muscle weakness During a review of Resident 51's MDS, dated 2/25/2026, the MDS indicated Resident 51 was cognitively intact with skills required for daily decision making. d. During a review of Resident 59's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 6/02/2022 with diagnoses that included hypotension (low blood pressure). During a review of Resident 59's MDS, dated 12/12/2025, the MDS indicated Resident 59 was cognitively intact with skills required for daily decision making.	F0577		

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F0577 SS = E	Continued from page 7 e. During a review of Resident 62's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 6/04/2025 with diagnoses that included osteoarthritis. During a review of Resident 62's MDS, dated 12/09/2025, the MDS indicated Resident 62 was cognitively intact with skills required for daily decision making. f. During a review of Resident 65's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 1/06/2025 with diagnoses that included muscle weakness. During a review of Resident 65's MDS, dated 1/13/2026, the MDS indicated Resident 65 was cognitively intact with skills required for daily decision making. g. During a review of Resident 83's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 10/01/2025 with diagnoses that included hypertension. During a review of Resident 83's MDS, dated 1/10/2026, the MDS indicated Resident 83 was cognitively intact with skills required for daily decision making. h. During a review of Resident 203's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 1/15/2026 with diagnoses that included muscle weakness. During a review of Resident 203's MDS, dated 1/21/2026, the MDS indicated Resident 203 was cognitively intact with skills required for daily decision making. i. During a review of Resident 219's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 12/01/2024 with diagnoses that included anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 219's MDS, dated 12/10/2025, the MDS indicated Resident 219 was	F0577		

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F0577 SS = E	Continued from page 8 cognitively intact with skills required for daily decision making. j. During a review of Resident 236's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on 4/24/2023 with diagnoses that included muscle weakness. During a review of Resident 236's MDS, dated 1/23/2026, the MDS indicated Resident 236 was cognitively intact with skills required for daily decision making. During a review of the facility's Resident Council Meeting Minutes, the minutes indicated no information that residents were made aware of the survey results on the following dates: 11/26/2025, 12/17/2025, and 1/29/2026. During an observation and interview with the residents during the resident council task meeting interview on 3/09/2026 at 2:36 p.m., 10 of the 11 residents (Resident 189, Resident 30, Resident 51, Resident 59, Resident 62, Resident 65, Resident 83, Resident 203, Resident 219, and Resident 236) stated they were not aware of survey results for them to review or where the survey results were located. The 10 residents stated no one told them about survey results. During an observation on 3/11/2026 at 7:45 a.m., observed survey results binder attached to the wall in an area near the first-floor nursing station which indicated the last recertification survey was 12/20/2024. During an interview with the Activities Director (AD) on 3/11/2026 at 9:04 a.m., she stated all survey results were posted near the dining room entrance on every floor and is within reach of the residents. The AD stated she has not told residents in the resident council meetings about the existence of the survey results or where they were located. The AD stated it is important for the residents to know about past survey results and where they are located. The AD stated many of the residents are very involved and active in what occurs in the facility and knowing about the survey results should be part of their involvement.	F0577		

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F0577 SS = E	Continued from page 9 During an observation with the AD on 3/11/2026 at 9:10 a.m., the AD showed the survey team the location of the fourth-floor survey results. Observed the survey binder in a holder near the dining area entrance containing the previous recertification survey results, dated 12/20/2024. During an observation on 3/11/2026 at 9:10 a.m., observed the survey binder in a holder near the third-floor dining area entrance containing the previous recertification survey results, dated 12/20/2024. During an interview with the Director of Nursing (DON) on 3/12/2026 at 8:30 a.m., the DON stated residents should be made aware of the previous year's survey results and their location. The DON stated the residents have the right to review the survey results to remain informed. During a review of facility's policy and procedures (P&P) titled, "Administrative Manual," reviewed on 4/16/2025, the P&P indicated, "Most recent licensing visit report (survey)/complaint investigations, and the related follow-up plan of correction visit, in areas of the facility that are prominent and accessible to the public have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the three preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review."	F0577		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status	F0580	F-580 Corrective Action for Affected Residents: On 3/12/2026, the RN Unit Manager notified Resident 94's physician of the multiple insulin refusals that occurred on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026. On 3/12/2026, the RN Unit Manager obtained physician orders for Resident 94 regarding the management of insulin refusals and alternative diabetes management strategies. Identifying other Residents having the Potential to be Affected: On 3/25/26, the Medical Records Manager conducted an audit of the Medication Administration Records (MARs) for residents receiving insulin for the period of 3/1/2026 through 3/25/2026 to identify instances where residents refused two or more consecutive doses. No other residents in the facility	04/11/2026

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F0580 SS = D	Continued from page 10 in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the physician was notified when one of two sampled residents (Resident 94) repeatedly refused insulin (medication to lower blood sugar) injection. This deficient practice placed Resident 94 at risk for delayed care and poor blood glucose management, placing	F0580	Continued from page 10 were identified as refusing insulin. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced licensed nurses on the “Medication Administration” policy, with emphasis on the requirement to notify physicians of two consecutive medication refusals, particularly insulin and other critical medications, and the importance of timely documentation of physician notification in the resident’s progress notes. Plan to Monitor Performance: Beginning 4/6/2028, the contracted Medical Records Consultant will conduct random audits during scheduled monthly visits of the MARs and corresponding progress notes for residents receiving insulin or other critical medications to verify that licensed nurses are notifying physicians when residents refuse two consecutive doses and documenting such notifications appropriately. The audits will include a sample size of at least ten percent of residents receiving insulin or other critical medications. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0580 SS = D	Continued from page 11 the resident at risk for health complications. Findings: During /a /review of Resident /94's /Face Sheet, the /Face Sheet /indicated the facility originally admitted Resident 94 on 10/01/2023 and re-admitted the resident on 1/12/2025, with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), with diabetic polyneuropathy (nerve damage caused by diabetes that makes feet or hands feel numb, tingly, or painful), and peripheral vascular disease(a condition where blood vessels outside heart and brain usually in legs become blocked or narrowed, causing poor blood flow). During a review of Resident 94's History and Physical (H & P) dated 2/27/2026, the H&P /indicated /Resident 94 does have the capacity to understand and make decisions on her own. The H&P indicated the Hemoglobin A1c (HbA1c, a blood test that shows your average blood sugar level over the past 2–3 months. The normal range is below 5.7 percent [%]) dated 8/21/2025 was 8.9%. The H&P indicated the HbA1c remains above goal, and the goal is less than 8%. During a review of Resident /94's Minimum Data Set /(MDS – a resident assessment tool), dated /1/02/2026, /the MDS indicated Resident /94 /has /intact /cognition (mental action or process of acquiring knowledge and understanding) for daily decision. During a review of Resident 94's Physician Order Report dated 3/1/2026 to 3/10/2026, the Physician Order Report indicated the following order, with the start date of 3/21/2025. -Novolog(fast acting insulin) insulin 8 units; subcutaneous (under skin) for DM ; please rotate the site, hold if blood sugar less than 100 milligrams per deciliter(mg/dl, a unit of measurement to indicate how many milligrams of as glucose are present in one deciliter [100 /mL] of blood), once a day, 7:30 a.m. During a review of Resident 94's Medication Administration Record (MAR) dated 3/01/2026 to 3/10/2026, the MAR indicated the following results for	F0580		

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F0580 SS = D	Continued from page 12 the Novolog 8 units subcutaneous order administered once daily at 7:30 a.m.: • 3/1/2026 at 7:20 a.m. – Not Administered: Refused • 3/4/2026 at 8:35 a.m. – Not Administered: Refused • 3/5/2026 at 8:22 a.m. – Not Administered: Refused • 3/6/2026 at 7:15 a.m. – Not Administered: Refused • 3/7/2026 at 7:58 a.m. – Not Administered: Refused • 3/9/2026 at 8:04 a.m. – Not Administered: Refused During a concurrent interview and record review on 3/10/2026 at 1:02 p.m., with the Director of Nursing (DON), Resident 94's Physician Order Report dated 3/01/2026 to 3/10/2026 was reviewed. The DON stated the order indicated that /Resident 94 should receive insulin Novolog 8 units every morning at 7:30 a.m. The DON stated Resident 94 has a tendency to refuse insulin injections. During a concurrent interview and record review on 3/10/2026 at 1:10 p.m., with the DON Resident 94's MAR dated 3/01/2026 to 3/10/2026 was reviewed. The DON stated the MAR indicated that /Resident 94 refused the scheduled Novolog injections at 7:30 a.m. on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026. The DON stated licensed nurses should have informed the physician that Resident 94 refused scheduled Novolog injections at 7:30 a.m. on those dates. The DON stated that it important to inform the physician when a resident refuses insulin so the physician can adjust the dose and help prevent complications such as high blood sugar or low blood sugar. During a concurrent interview and record review on 3/10/2026 at 1:17 p.m., with the DON, Resident 94's progress notes dated 3/1/2026 to 3/10/2026 was reviewed. The DON stated he was unable to find documented evidence that licensed nurses informed the physician that Resident 94 refused the scheduled 7:30 a.m. insulin injection on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026. During a concurrent interview and record review on 3/12/2026 at 8:18 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 94's MAR and progress notes dated	F0580		

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F0580 SS = D	Continued from page 13 3/01/2026 to 3/10/2026 were reviewed. LVN 4 stated that /Resident 94 refused the scheduled 7:30 am insulin injection on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026. LVN 4 stated she is unable to find any documentation in the progress notes indicating the physician was informed of Resident 94's repeated refusal of insulin for 3/2026 .LVN 4 stated not notifying the physician had the potential to result in Resident 94 not receiving the right amount of medication which can lead to complications such as high blood sugar which could result in the resident experiencing increased thirst, headaches, blurred /vision or low blood which could result in coma (deep state of unconsciousness where a person is not awake and cannot respond to their surroundings, including voice, touch, or pain), confusion or shakiness. LVN 4 further stated that notifying the physician will allow the physician to adjust the dose accordingly and determine an appropriate plan. During a concurrent interview /and record review /on /3/11/2026 /at /8:38 /a.m., /with /the DON, the facility's policy and procedure (P&P) titled, /"Medication Administration" /was reviewed. /The /"Medication Administration," revised on 4/16/2025, indicated the DON and the attending physician must be notified when two consecutive doses of medication are refused or withheld. The DON stated that the licensed nurses should have notified the physician when Resident 94 refused insulin injection on 3/4/2026, 3/5/2026, 3/6/2026, and 3/7/2026 since the refusal occurred on consecutive days. The DON stated licensed nurses did not notify the physician and facility policy was not followed. The DON stated failure to notify the physician could result in the physician being unable to adjust the insulin accurately and the resident may not receive the right amount of insulin in the body. During a /review of the facility's P&P titled, "Medication Administration," revised on /4/16/2025, the P&P indicated /medications will be administered in a timely manner and as prescribed by the resident's/patient's attending physician or the facility's medical director. Charting Withholding/ Refusal of Medication on the MAR. Should a drug be withheld, refused, or given other than the schedules time, the individual administering the medication must initial and circle the MAR space provided for that particular drug. The Director of Nursing services and attending physician must be notified when two consecutive doses of medication are refused or	F0580		

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F0580 SS = D	Continued from page 14 withheld.	F0580		
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to safeguard resident confidentiality and privacy when a medication cart computer screen was left open and unattended on one of five medication carts (Medication Cart 3). This deficient practice had the potential to result in	F0583	F-583 Corrective Action for Affected Residents: On 3/9/2026, the medication cart computer screen was immediately closed by Registered Nurse (RN) 6 to prevent further unauthorized viewing of resident information. Only the surveyor saw the open computer screen. The LVN realized she left it open and returned to close it but the RN had already closed it. Identifying other Residents having the Potential to be Affected: No additional residents were identified as having their personal health information left viewable on unattended computer screens during follow up rounds. Measures put into place or Systemic Changes: RN Unit Manager (RN 6) met with Licensed Vocational Nurse (LVN) 8 to provide supervisory intervention regarding the importance of closing computer screens displaying resident information when stepping away from medication carts to prevent unauthorized disclosure of protected health information. The DON and/or Director of Education in-serviced licensed nursing staff (Registered Nurses and Licensed Vocational Nurses) on the facility's policies and procedures titled "Medication Administration" and "Patient Protected Health Information" with emphasis on: 1) closing or covering the Medication Administration Record when not attended to protect resident confidentiality; 2) closing documents and signing out of software programs when temporarily distracted by another duty; 3) ensuring computer screens are not left open and unattended; and 4) the HIPAA privacy implications of leaving resident information visible on unattended devices. Plan to Monitor Performance: Beginning 4/6/26, the RN Unit Manager or designee will conduct random observations of medication carts during medication passes weekly to ensure computer screens are closed when medication carts are unattended. The audit tool will document the date, time, medication cart number, whether the computer screen was closed when unattended, and any corrective action needed. If non-compliance is identified, the DON or designee will provide immediate re-education and supervisory intervention to the responsible licensed nurse. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is	04/11/2026

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F0583 SS = D	Continued from page 15 unauthorized disclosure of residents' personal information. Findings: During an observation /on /3/9/2026 at 9:19 a.m. /in between the nursing station and /main dining room on the second floor of the facility, /observed Team B medication cart unattended with the computer screen open to a resident's electronic Medication Administration Record (eMAR – a digital system to track and manage medication administration for resident). Registered Nurse (RN) 6 was observed calling out a name while approaching the medication cart, took steps to remove the eMAR from view on the screen and walked away from the medication cart. During an interview on 3/9/2026 at 922 a.m. with Registered Nurse (RN) 6, RN 6 stated she observed that the computer screen was left open displaying resident information and minimized the window screen (hide the screen) because of Health Insurance Portability and Accountability Act (HIPPA – US federal law designed to protect sensitive patient health information from disclosure without consent). RN 6 stated leaving the window open leaves residents' information to be seen by others. RN 6 stated she left the medication cart after minimizing the window screen to let the charge nurse know of the incident. During an interview on 3/9/2026 at 9:30 a.m. with Licensed Vocational Nurse (RN) 8, LVN 8 stated RN 6 informed her right away of her mistake of leaving the medication cart computer screen open. LVN 8 stated she should not have left the screen open displaying resident information because of HIPPA. LVN 8 stated that leaving the screen open had the potential for residents' personal information to be exposed and their privacy unprotected. During an interview on 3/12/2026 at 10:05 a.m. with the Director of Nursing (DON), the DON stated leaving a computer screen open to resident's medical record is a HIPPA concern. The DON stated leaving a computer screen open to a resident's medical record compromises privacy and confidentiality. During a review of the facility's policy and procedure (P&P) titled, "Medication Administration" last reviewed	F0583	Continued from page 15 achieved.	

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F0583 SS = D	Continued from page 16 4/16/2026, the P&P indicated, “The MAR should be closed or covered when not attended to protect resident/patient confidentiality”. During a review of the facility’s P&P titled, “Patient Protected Health Information” last reviewed 4/16/2026, the P&P indicated, “It is the policy of Los Angeles Jewish Health (LAJH) that all LAJH employees take every reasonable precaution in order to assure that patient protected information (PHI) is secure and will not be open to unwarranted exposure…LAJH employees using electronic devices will not leave them open for viewing and unattended should they be temporarily distracted by another duty. They will close the document and sign out of the software program… Screens should not be left open and unattended”.	F0583		
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584	F-584 Corrective Action for Affected Residents: On 3/12/2026, the Maintenance Manager (MM) or designee removed the tape and repaired the carpet in the shared room #1206 of Resident 95 and Resident 111 to ensure a safe and homelike environment. On 3/12/2026, the Environmental Services Director conducted a room safety assessment for room #1206 for Resident 95 and Resident 111 to ensure no additional environmental safety concerns were present in their shared room. Identifying other Residents having the Potential to be Affected: The Environmental Services Director or designee conducted a comprehensive inspection of the carpet in resident rooms and created a list of 9 additional rooms needing repair. Of these, 6 were able to be repaired by in-house environmental services department and 3 were repaired by a contracted floor repair company. Work was completed on 4/1/2026. Measures put into place or Systemic Changes: The facility’s Manager Rounds audit tool was updated on 4/2/26 to include monthly documented flooring condition inspections of a minimum of 5 rooms per floor (more than 10%) and in the common areas. Any findings will be documented and communicated to the EVS Director or designee for timely follow up with repairs. The Environmental Services Director or designee in-serviced the Environmental Services Department on the requirement to notify the EVS Director or Supervisor of any rooms requiring repairs and the impact on residents’ safety and their right to have a homelike environment in their rooms.	04/11/2026

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F0584 SS = D	Continued from page 17 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment for two of five sampled residents (Residents 95 and 111) when the carpet in the residents' shared room was in disrepair. This deficient practice denied Residents 95 and 111 the right to a safe and homelike environment and had the potential to negatively impact their quality of life. Findings: During a review of Resident 95's Face Sheet, the Face Sheet indicated the facility admitted the resident on 1/1/2022 with diagnoses including, but not limited to, Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) and dementia (a progressive state of decline in mental abilities). During a review of Resident 95's Minimum Data Set (MDS – a resident assessment tool), dated 1/26/2026, the MDS indicated the resident had severely impaired cognitive (relating to or involving the processes of thinking and reasoning) skills necessary for daily decision making and never or rarely made decisions. The MDS indicated Resident 95 was dependent (helper does all of the effort) on staff for all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily).	F0584	Continued from page 17 Plan to Monitor Performance: The EVS Director and/or Supervisor or designee will conduct weekly audits to verify floor is in good condition. Team Leaders will conduct monthly Manager Rounds and will inspect a minimum of 25 rooms (5 per floor) and document if the flooring in any resident rooms or common areas need repair and this will be communicated to the EVS Director or designee for timely repairs. Administrator or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee which meets at least quarterly. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0584 SS = D	Continued from page 18 During a review of Resident 111's Face Sheet, the Face Sheet indicated the facility admitted the resident on 9/18/2023 with diagnoses including, but not limited to, bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 111's MDS, dated 12/24/2025, the MDS indicated the resident had severely impaired cognitive skills necessary for daily decision making and never or rarely made decisions. The MDS indicated Resident 111 was dependent on staff for all ADLs. During a concurrent observation and interview on 3/9/2026 at 10:32 a.m. with Resident 95's family member (FM 2) in Resident 95 and Resident 111's shared room, an area of the carpet had a linear cut in a rectangular shape with three cut sides. FM 2 stated someone had put tape over the cut area but now the tape was old and the whole area did not look nice. FM 2 put her foot in the cut area of the carpet and lifted part of the carpet up. FM 2 stated someone could trip on the carpet. FM 2 stated the carpet had been this way for at least two years. FM 2 stated someone from the facility had told her in the past it would be replaced but they never did it. During a concurrent observation and interview on 3/11/2026 at 3:10 p.m. with the Maintenance Manager (MM) in Resident 95 and Resident 111's shared room, the MM observed and validated the carpet was cut and the tape was missing over parts of the cut area. The MM observed and validated the cut area of the carpet could be lifted. The MM stated someone could trip in this area, the carpet does not look like it should, and the tape looked worn and peeling. During an interview on 3/12/2026 at 9:12 a.m. with the Director of Nursing (DON), the DON stated although the residents in the room were unable to walk, someone like a staff member could trip on that area of carpet. The DON stated the carpet does not look nice. During a concurrent observation and interview on 3/12/2026 with the MM, the MM stated the cut area in the carpet was approximately four by two-and-a-half	F0584		

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F0584 SS = D	Continued from page 19 feet. During a review of the facility's policy and procedure (P&P) titled, "Accommodation of Needs," last reviewed 4/16/2025, the P&P indicated in order to create an individualized, homelike environment, each resident has the right to resident and receive services in the facility with reasonable accommodation or resident needs and preferences. During a review of the facility's policy and P&P titled, "Work Environment," last reviewed 4/16/2025, the P&P indicated a safe and healthful work environment will be provided for all employees, residents, and visitors.	F0584		
F0585 SS = D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings	F0585	F-585 Corrective Action for Affected Residents: On 3/9/2026, the Director of Social Services (DSS) completed a comprehensive Issues and Concerns form documenting Family Member (FM) 1's September 2025 email as well as an email dated 3/8/26 received on 3/9/26. On 03/9/2026, the DSS and RN Unit manager verbally and in writing acknowledged receiving a grievance via email with Resident 222 and FM 1. The DSS asked Resident 222 what would make her feel safe and respected, and ensured that her preferences for care staff assignments were documented and communicated to nursing leadership. On 3/9/2026, CNA 5 was reassigned and is no longer providing care to Resident 222, this was communicated to FM 1 and Resident 222 and they communicated gratitude and felt resident's needs were met in a safe environment. On 3/10/2026, the Director of Social Services (DSS) held IDT meeting with Resident 222 in person and FM 1 via phone to acknowledge the concern raised in September 2025 regarding Certified Nursing Assistant (CNA) 5's interaction with Resident 222. The DSS apologized for the failure to follow the facility's grievance process and validated Resident 222's experience. The DSS followed up for the remainder of the week with Resident 222 to ensure her needs continued to be met. A written email was sent to FM 1 with a summary of the follow up based on her concern on 3/31/26. Identifying other Residents having the Potential to be Affected: DSS reviewed the Tracking Log for Issues and Concerns - Grievances from September 2025 through March 2026 to identify any other written or other concerns or complaints that were not processed through the facility's grievance policy and procedure. Social	04/11/2026

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F0585 SS = D	Continued from page 20 in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State	F0585	Continued from page 20 Worker (SW) 1 is no longer working at JEKMC. No other concerns were identified that were not properly processed. 3/31/26 Measures put into place or Systemic Changes: The ADM and DSS reviewed the facility's policy and procedure titled 'Issues and Concerns – Grievances Process' to include timeframes for acknowledging receipt of a grievance, conducting investigations, and issuing written decisions for written concerns. On 3/16/26, the DSS the Social Services Department and on 3/31/26 the Administrator in-serviced the Director of Nursing (DON), Registered Nurses (RNs), and other department managers on the facility's grievance policy and procedure, including the requirement to assist residents and family members in filing grievances, the process for logging and tracking concerns, the requirement to interview both the complainant, the resident and staff as appropriate, the documentation requirements for written grievance decisions, and the requirement to maintain grievance records for three years. Issue and Concern – Grievance Forms are available at the nurses' stations. The in-service included case scenarios similar to the situation involving Resident 222 to illustrate proper grievance handling. In addition, "Patient Safety Concern Reporting" forms and a locked drop box are available next to the consumer board on the first floor. Residents were educated regarding this during the 3/19/26 Resident Council Meeting. Plan to Monitor Performance: Beginning 4/6/26, the DSS or designee will conduct weekly audits of concerns or complaints received to ensure that the facility's grievance policy and procedure is being followed and is timely. The audit will include verification that the Administrator was notified, the complainant was contacted within 24 hours of receipt, an Issues and Concerns form was completed, interviews were conducted with the complainant and the resident, and a decision was issued that includes the date the grievance was received, a summary statement of the grievance, the steps taken to investigate, a summary of the pertinent findings or conclusions, corrective actions taken or to be taken, and the date the written decision was issued, and that the grievance documentation is being maintained in a secure location. The ADM or designee will review the centralized grievance tracking system monthly to ensure that concerns are being logged and tracked through to conclusion. The DSS or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until	

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F0585 SS = D	Continued from page 21 Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to implement its grievance policy and procedure for one out of two residents (Resident 222) when the facility failed to assist Resident 222's family member in filing a grievance related to the care provided to Resident 222 by Certified Nursing Assistant (CNA) 5 and failed to conduct an investigation into the concerns. This deficient practice violated Resident 222's right to have a grievance addressed, had the potential to negatively affect Resident 222's care, and had the potential to cause Resident 222 to feel invalidated and disrespected. Findings: During a review of Resident 222's Face Sheet, the Face Sheet indicated the resident was admitted on 4/21/2025 with diagnoses including, but not limited to, rheumatoid arthritis (a chronic progressive disease-causing inflammation in the joints and resulting in painful deformity and immobility), fibromyalgia (a chronic disorder characterized by widespread pain and other symptoms such as fatigue, muscle stiffness, and insomnia), and dementia (a progressive state of decline in mental abilities). During a review of Resident 222's Minimum Data Set (MDS – a resident assessment tool), dated 1/31/2026, the MDS indicated the resident had moderate cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 222 was dependent (helper does all the effort) on staff for lower body dressing and putting on footwear. The MDS indicated Resident 222 required substantial assistance (helper does more than half of the effort) with upper body dressing and toileting. The MDS indicated Resident 222 required partial assistance (helper does less than half of the effort) with personal hygiene. The MDS indicated Resident 222 required supervision or touching	F0585	Continued from page 21 substantial compliance of the set-forth protocol is achieved.	

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F0585 SS = D	Continued from page 22 assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) with oral hygiene and bathing. During a review of the Tracking Log for Issues and Concerns, dated March 2025 to February 2026, the log did not indicate a grievance, issue, or concern was logged involving Resident 222. During an interview on 3/9/2026 at 11:05 a.m. with Resident 222, Resident 222 stated that CNA 5 had spoken in ways that were not nice to her in the past. Resident 222 stated a few months ago after using the bathroom she asked CNA 5 to help her pull up her brief (a high-absorbency incontinence garment). Resident 222 stated CNA 5 then told her she could do that herself and then called her lazy. Resident 222 stated her family member had reported this to the social worker. During a telephone interview on 3/9/2026 at 2:28 p.m. with Family Member (FM) 1, FM 1 stated she sent an email in September 2025 to Social Worker (SW) 1 informing her that CNA 5 was unkind to Resident 222 and had called her lazy. FM 1 stated no one from the facility had followed up with her after her email. FM 1 stated she sent another email on 3/8/2026, and today (3/9/2026) CNA 5 was no longer assigned to provide care to Resident 222. During an interview on 3/9/2026 at 3:47 p.m. with the facility administrator (ADM), the Director of Social Services (DSS), and Registered Nurse (RN) 7, the ADM stated FM 1 had emailed SW 1 about this concern in September 2025, but SW 1 was no longer employed at the facility. RN 7 stated she became aware of FM 1's concern when SW 1 told her about it in September 2025. RN 7 stated she spoke to CNA 5, and CNA 5 stated she never called Resident 222 lazy. The DSS stated she became aware of FM 1's concern this morning (did not specify time) when she read the email FM 1 sent last night. The DSS stated she was not aware of the email FM 1 sent to SW 1 in September 2025. The ADM stated there was no grievance filed in September 2025 when FM 1 sent the first email. The ADM stated the best practice would have been to file a grievance at that time. During an interview on 3/10/2026 at 4:04 p.m. with FM 1 and Resident 222, FM 1 stated when she sent the email in September 2025, she was not informed of the	F0585		

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F0585 SS = D	Continued from page 23 facility's grievance process or how to file a grievance. Resident 122 stated she was not aware of how to file a grievance. Resident 222 stated her interaction with CNA 5 was upsetting and made her feel uncomfortable. During an interview on 3/12/2026 at 2:47 p.m. with the ADM, the DSS, and RN 7, RN 7 stated after she was made aware of FM 1's concern in September 2025, she spoke to CNA 5 but did not speak to FM 1 or Resident 222. RN 7 stated she was not aware if anyone had spoken to FM 1 or Resident 222 to follow up on the concern. The ADM stated once they are aware of a concern they should go to the source, listen fully to the concern, and validate them. The ADM stated they should follow their proper process to address their concerns, make sure the resident feels safe, and ensure that they are treated in a respectful and dignified way. The ADM stated she would have expected SW 1 to forward FM 1's concern to the DSS who was her supervisor, then interview FM 1 and ask clarifying questions. The ADM stated she would then expect SW 1 to speak directly with Resident 222 to hear her experience and ask what she would like to be done and if she would like a different CNA to be assigned to her. The DSS stated all of these actions should have been documented and the facility's Issues and Concerns form should be filled out. The DSS stated when she learned of the concern on 3/9/2026 she completed an Issues and Concerns form. The ADM stated the resident could potentially have felt unheard, invalidated, not respected, or not believed. During a review of the facility's policy and procedure (P&P) titled, "Issues and Concerns Process," last reviewed 4/16/2025, the P&P indicated the following: a. Grievances are referred to as Issues and Concerns for the purpose of the policy and the form associated with it. b. The facility with assist residents, their representatives, and other interested family members in filing issues or concerns when such requests are made. c. Issues and concerns can be submitted orally or in writing. d. Once a verbal or written issue or concern is received the respective department will investigate allegations and submit a written report to the administrator.	F0585		

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F0585 SS = D	Continued from page 24 e. The person filing the issue or concern will be informed of the findings of the investigation and the action that will be taken to correct any identified problems. f. If the resident or their representative is not satisfied with the result of the investigation or recommended actions they can appeal to the administrator or compliance officer. g. Records of grievances will be maintained for three years.	F0585		
F0605 SS = E	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints	F0605	F-605 Corrective Action for Affected Residents: On 3/12/2026, Resident 81's medical record was reviewed by the RN Unit Manager to identify any adverse consequences related to the lack of orthostatic blood pressure monitoring. On 3/27/2026, the RN Unit Manager communicated with Resident 81's physician regarding the missed orthostatic blood pressure monitoring from 8/1/2025 through 3/12/2026. Order was revised to take blood pressure lie supine and sitting only since resident is unable to stand up and to notify physician when systolic blood pressure drops greater than 20 points to determine if any medication adjustments or interventions are needed based on the monitoring data. Identifying other Residents having the Potential to be Affected: On 3/30/2026, the Medical Records Manager conducted an audit of the medical records of residents currently prescribed antipsychotic medications to identify other residents with physician orders for orthostatic blood pressure monitoring. On 3/31/2026, the RN Unit Managers and/or MDS Coordinators reviewed the compliance rate of orthostatic blood pressure monitoring for these residents over the past month to identify gaps in monitoring. Providers were contacted for any residents who are unable to obtain orthostatic blood pressure to determine if any medication adjustments or interventions are needed and document accordingly. 15 resident's orders were updated due to resident unable to complete orthostatic blood pressure. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced licensed nurses and CNAs on the facility's policy and procedures for orthostatic blood pressure monitoring, including the importance of monitoring residents on psychotropic medications for side effects such as orthostatic hypotension. Education on the proper documentation requirements when orthostatic blood pressure monitoring cannot be completed, including the need to document the	04/11/2026

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F0605 SS = E	Continued from page 25 imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an	F0605	Continued from page 25 reason in the medical record and communicate the inability to complete the monitoring to the physician, was included. Plan to Monitor Performance: Beginning 4/6/2026, Health Information System department will conduct weekly audits of medical records for residents prescribed antipsychotic medications with orders for orthostatic blood pressure monitoring to verify that monitoring is being performed and documented as ordered. The audit will include verification that any inability to complete monitoring is documented with the reason and communicated to the physician. The RN Unit Manager or designee will review audit results with the DON or designee weekly to identify any ongoing compliance issues. If the audit identifies missed orthostatic blood pressure monitoring or inadequate documentation, the RN Unit Manager or designee will immediately review the resident's medical record with nursing staff and ensure corrective action is taken, including contacting the provider. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee which meets at least quarterly. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0605 SS = E	Continued from page 26 effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure adequate monitoring of resident's orthostatic blood pressure (taking blood pressure measurements when lying, sitting, and standing to detect for significant drop in blood pressure during each position change) when taking a prescribed antipsychotic medication for one out of five residents (Resident 81) reviewed under unnecessary medications. This failure had the potential to result in Resident 81 receiving inappropriate dosage of an antipsychotic medication and experiencing symptoms of orthostatic hypotension (a significant drop in blood pressure with position change), which could lead to serious complications such as fainting and falls. Findings: During a review of Resident 81's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the facility originally admitted Resident 81 on 6/29/2023, with diagnoses including: vascular dementia (loss of cognitive functioning-thinking, remembering, and reasoning), psychosis (a mental health symptom involving a loss of contact with reality) and	F0605		

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F0605 SS = E	Continued from page 27 major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). During review of Resident 81's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 12/17/2025, the MDS indicated Resident 81 has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and is dependent (helper does all the effort) for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 81's Physician Order Report, the Physician Order Report indicated Resident 81 has a physician order for Seroquel (an antipsychotic medication used to treat mental health conditions) 12.5 milligrams (mg-unit of measurement) every day at bedtime, dated 8/8/2025. /The physician's order also indicated to monitor for side effects of Seroquel use: which includes headache, somnolence (state of being sleepy or drowsy), weight gain, orthostatic hypotension, anticholinergic effects (confusion, constipation, dry mouth, blurry vision, urinary retention), dizziness, hypotension (low blood pressure), and tardive dyskinesia (uncontrollable, repetitive, and abnormal body movements). Orthostatic blood pressure was ordered to be taken every Saturday evening. During a concurrent interview and record review with Registered Nurse Supervisor (RN) 3 on 3/12/2026 at 12:10 pm, Resident 81's medical record was reviewed. Resident 81's medical record did not indicate documented evidence of orthostatic blood pressure monitoring being performed from 8/1/2025 through 3/12/2026. RN 3 stated the certified nursing assistant (CNA) or licensed vocational nurse (LVN) should document why the orthostatic blood pressure could not be taken and communicate that to the physician. RN 3 stated there was no documentation on Resident 81's medical record why orthostatic blood pressures were not taken and confirmed there was no communication with the physician regarding the inability to monitor blood pressures. During an interview on 3/12/2026 at 2:00 pm with the Director of Nursing (DON), the DON stated the inability	F0605		

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F0605 SS = E	Continued from page 28 to take the orthostatic blood pressure for psychotropic monitoring should be documented in the medical record and communicated to the physician because if the nurses do not document the orthostatic blood pressures, the physician will not know if the resident is having side effects from Seroquel and cannot make adjustments to the medication or interventions if needed. During a review of facility's policy and procedures (P&P) titled, "Orthostatic Blood Pressure," reviewed on 4/2025, the P&P indicated, "Orthostatic vital signs shall be taken and recorded when ordered by the physician." During a review of the facility's P&P titled, "Medication (Psychotherapeutic Drug Management)," reviewed 4/2025, the P&P indicated the facility will monitor all psychotherapeutic medications for effectiveness and side effects like postural hypotension.	F0605		
F0640 SS = D	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and	F0640	F-640 Corrective Action for Affected Residents: On 3/11/2026, Resident 87's annual Minimum Data Set (MDS) assessment dated 1/11/2026 was transmitted to the Centers for Medicare and Medicaid Services (CMS) Quality Improvement Evaluation System (QIES) Assessment Submission and Processing (ASAP) System. The MDS Coordinator or designee reviewed Resident 87's current assessment data on 3/12/2026 to ensure all encoded information accurately reflects the resident's clinical status and is properly submitted in the CMS system. Identifying other Residents having the Potential to be Affected: On 3/30/2026, the MDS Coordinator conducted a comprehensive audit of the MDS 3.0 Final Validation Report to identify residents with pending assessments requiring transmission to CMS for the past three months, none were identified as pending. Measures put into place or Systemic Changes: The Director of Nursing (DON) reviewed the facility's Policy and Procedure titled "Transmitting MDS Data" and "Minimum Data Set – Resident Assessment Instrument" with the MDS Coordinator to reinforce the regulatory requirements for encoding assessments within 7 days of completion and transmitting assessments within 14 days of completion. The in-service will include review of the MDS 3.0 Final Validation Report to monitor submission status and ensure assessments are transmitted timely. The DON updated the "Stand Up	04/11/2026

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F0640 SS = D	Continued from page 29 data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident's Minimum Data Set (MDS) annual assessment was transmitted to Centers for Medicare and Medicaid Services (CMS, a federal government agency that manages the Medicare and Medicaid programs, which provide health coverage to people) within the required 14 day timeframe for one of one sampled residents (Resident 87) reviewed under the resident assessment facility task. This deficiency prevents the CMS from having the most accurate information of Resident 87 and had the potential to result in delayed services for the resident.	F0640	Continued from page 29 Meeting Routine Questionnaire" to include a weekly audit of the transmission validation report. Any assessments identified as not having been transmitted will be transmitted. Plan to Monitor Performance: Beginning 4/6/26, the DON or designee will conduct audits of the MDS tracking log and the MDS 3.0 Final Validation Report weekly for four consecutive weeks to verify that assessments are encoded within 7 days of completion and transmitted to the QIES ASAP System within 14 days of completion. If any deficiencies are identified during the audit, the DON will provide immediate supervisory intervention to the MDS Coordinator and ensure the assessment is transmitted within 24 hours of identification. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0640 SS = D	Continued from page 30 Findings: During a review of Resident /87's /Face Sheet, /the /Face Sheet indicated the facility admitted Resident /87 /on /3/23/2025 /with diagnoses including /chronic obstructive pulmonary disease (COPD - a progressive, long-term lung disease that makes it hard to breathe by restricting airflow), major depressive disorder (a mental health condition with persistent feelings of sadness and hopelessness.) and ileostomy (a surgical opening that lets stool pass from your body without going through your colon) During a review of Resident /87's Minimum Data Set (MDS – an assessment and care screening tool) dated /1/11/2026, /the MDS indicated the Resident 87 makes himself understood and understood others. The MDS further /indicated /Resident /87 /needed partial assistance (helper does less than half the effort) with toileting, upper body dressing, lower body dressing, putting on/taking off shoes and personal hygiene. During a review of Resident 87's Final Validation CMS Submission Report titled "MDS 3.0 Final Validation Report," printed on 3/12/2026, the report indicated Resident 87's assessment was submitted and processed on 3/11/2026 at 15:08 (3:08 p.m.). The MDS was completed on 1/11/2026 but not transmitted until 59 days later on 3/11/2026. During a /concurrent /interview /and record review /on 3/11/2026 at /11:45 /a.m. with Minimum Data Set Coordinator 3 /(MDSC 3), MDSC 3 reviewed Resident 87's annual assessment. MDSC 3 stated once the annual assessment is complete, it must be transmitted to CMS within 14 days to ensure CMS has the most updated and accurate information on each resident. MDSC 3 stated he forgot to validate and submit Resident 87's assessment after it was completed. During an interview on 3/12/2026 at 1:32 p.m. with the Director of Nursing (DON), the DON stated MDS annual assessments must be completed on time and then submitted to CMS within 14 days. The DON stated Resident 87's annual assessment was submitted 59 days after completion and about 45 days too late. The DON stated it is important to submit the MDS annual assessments timely to ensure CMS has the most accurate information on each resident.	F0640		

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F0640 SS = D	Continued from page 31 During a review of the facility provided /Policy and Procedure (P&P) /titled, “Transmitting MDS Data,” last reviewed on 4/16/2025, the P&P /indicated that “after the completion of the required assessment and/or tracking records, each provider must create electronic transmission files that meet the requirements detailed in the current MDS 3.0 Data Submission Specifications. During a review of the facility provided P&P titled, “Minimum Data Set – Resident Assessment Instrument,” last reviewed on 4/16/2025, the P&P indicated the MDS coordinator must transmit to the state repository in accordance with CMS established record specifications and time frames.	F0640		
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F0656	F-656 Corrective Action for Affected Residents: On 03/12/2026, the MDS Coordinator reviewed Resident 1’s wound assessment documentation and confirmed the wound was identified as moisture-associated skin damage (MASD) on 03/03/2026. A comprehensive individualized care plan for MASD was developed and implemented on 03/17/2026, including interventions for moisture management and barrier cream application. On 03/11/2026, MDS Coordinator reviewed Resident 180’s care plan and added the concave mattress as a fall prevention intervention to reflect the interdisciplinary team (IDT) agreement from 02/05/2021. On 03/12/2026, the Activities Director or designee reviewed Resident 4’s care plan and added specific interventions to address the resident’s preferred activity of listening to music, including offering music during awake hours and incorporating music into daily routines. On 03/9/2026, the MDS Coordinator developed and implemented a comprehensive care plan for Resident 72 addressing Transmission Based Precautions (TBP) for Clostridioides difficile (C.diff), including contact isolation precautions, hand hygiene protocols, and environmental cleaning requirements. On 03/27/2026, the MDS Coordinator reviewed Resident 81’s care plan for monitoring Seroquel side effects and created an individualized care plan specifying how to obtain orthostatic blood pressures given the resident’s functional limitations, including measuring blood pressures in lying position in bed and in reclining	04/11/2026

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F0656 SS = E	Continued from page 32 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility /failed to /develop and implement a comprehensive person-centered care plan (a document outlining a detailed approach to care customized to an individual resident's need) for: 1.One of two sampled residents (Resident 1) with a moisture associated damage (MASD) investigated during review of pressure ulcer/pressure injury (PU/PI – injury to the skin and underlying tissue resulting from prolonged pressure on the skin). 2. One of two sampled residents (Resident 180) whose care plan did not include all interventions agreed upon by the interdisciplinary team (IDT – a collaborative group of health care team members from different specialties who work together to address all aspects of resident's well-being) investigated for falls. These /deficient practices /had the potential to negatively affect the provision of care and service provided for the residents. 3. One of /two /sampled residents (Resident 4) to address the resident's preferred activity of listening to music investigated under activities.	F0656	Continued from page 32 wheelchair position. Identifying other Residents having the Potential to be Affected: Minimum Data Set Coordinators (MDSC) conducted a review of residents with moisture-associated skin damage (MASD). Five (5) additional residents were identified with MASD and MDS audited to ensure care plans are in place. The RN Unit Managers conducted an audit per unit to identify residents using concave mattresses for fall prevention. Minimum Data Set Coordinators (MDSC) reviewed care plans for residents with concave mattresses to ensure IDT recommendations are documented in post-fall assessments are incorporated into care plans. Thirteen residents were identified as needing concave mattress care plans and they were updated by MDSC. 3/31/26 On 3/30/26, the Activities Director or designee will review care plans for residents with identified activity preferences documented in Minimum Data Set (MDS) Section F to ensure preferred activities are reflected in individualized care plans. Documentation for three (3) additional residents was found to not match between the MDS and care plans and these were updated. On 3/24/26 the Infection Preventionist (IP) identified two additional residents on transmission based precautions. The MDS Coordinators reviewed residents and updated the comprehensive care plans addressing isolation precautions in place. 3/30/26 Medical Records Manager provided list of residents receiving antipsychotic medications requiring side effect monitoring to ensure care plans include individualized interventions when standard monitoring methods cannot be completed. RN Unit Managers and MDSC followed up with providers for 15 additional residents because monitoring was unable to be completed. Provider modified orders and care plans were updated. Completed 4/1/2026 Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced Licensed Nurses on the requirement to update care plans immediately when wound assessments result in diagnosis changes, ensuring care plans reflect current conditions rather than outdated assessments. The "Stand Up Meeting Routine Questionnaire" form was updated to include verification the care plan is updated to reflect changes in skin condition.	

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F0656 SS = E	Continued from page 33 This deficient practice /had potential for /Resident 4 /to /not receive /his preferred activity which can /affect the /resident`s sense of self- worth and well-being. 4. One /of five sampled residents (Resident 72) /on Transmission Based Precautions (TBP - /extra infection control measures used in healthcare settings, beyond standard precautions, for patients known or suspected to be infected with highly /infectious pathogens [virus, bacteria, fungus]) investigated during the infection control task. This deficient practice /had potential for /Resident /72 /to /not receive /the necessary care and services /needed /to prevent the spread of infection. 5. One of five sampled residents (Resident 81) when orthostatic blood pressures (taking blood pressure measurements when lying, sitting, and standing to detect for a significant drop in blood pressure during each position change) could not be done to monitor for side effects of /Seroquel /(prescription medication /to treat mood disorder or used as an antipsychotic). This failure had the potential to /have the resident receive improper medication usage, unmonitored side effects, and incorrect dosage of /Seroquel. Findings: 1. During a review of Resident 1's Face Sheet (FS - the front page of the chart that contains a summary of basic information about the resident), the FS indicated the facility admitted Resident 1 to the facility on 01/10/2026. The FS indicated Resident 1 was admitted with diagnosis that included bacterial pneumonia (serious lung infection caused by bacteria), chronic respiratory failure (long-term condition where the lungs cannot sufficiently transfer oxygen into the blood) and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). During a review of the History and Physical (H&P) report completed on 1/13/2026, the H&P indicated Resident 1 is able to make her own needs known and has the capacity to make her own medical decisions.	F0656	Continued from page 33 The DON or designee will implement a process requiring that post-fall IDT recommendations are care planned by the MDSC following the post fall IDT meeting. The "Stand Up Meeting Routine Questionnaire" form was updated to include verification the care plan is updated to reflect recommendations such as a concave mattress. The Activities Director or designee will implement a process to review MDS Section F activity preferences upon completion of each MDS assessment and update care plans to reflect resident-specific preferred activities within 7 days of MDS completion. The Activities Director in-serviced Activities staff on individualizing care plans to include specific preferred activities identified in MDS assessments and during conversations with residents. 3/30/26 The Infection Preventionist (IP) or DON will implement a process requiring that when a resident is placed on TBP, the licensed nurse will notify the DON and/or the IP and the license nurse will develop and implemented a care plan for isolation. The MDSC will validate the completion of the care plan. The "Stand Up Meeting Routine Questionnaire" form was updated to include this element. The DON and/or Director of Education in-serviced licensed nursing staff on the requirement to develop comprehensive care plans for residents on TBP upon identification of the need for isolation precautions, including specific interventions for contact precautions, droplet precautions, or airborne precautions as indicated. The DON or designee will educate licensed nurses and implement a process requiring that when care plan interventions cannot be completed as written, licensed nursing staff must document the barrier and notify the MDSC and RN Unit Manager so the care plan can be revised to include individualized alternative interventions. The "Stand Up Meeting Routine Questionnaire" form was updated to include verification the care plan is updated to reflect unable to obtain orthostatic blood pressure. Plan to Monitor Performance: Beginning 4/6/2026, the Medical Records consultant will audit during scheduled monthly visit that care plans are in place for the following areas: skin condition changes, post fall IDT recommendations are implemented, Section F of MDS match care plans, residents on transmission based precautions, and for residents unable to obtain orthostatic blood pressure. The DON or designee will report monitoring plan results	

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F0656 SS = E	Continued from page 34 During a review of Resident 1's Minimum Data Set (MDS – a resident assessment tool), dated 2/26/2026, the MDS indicated Resident 1 is able to make self-understood and able to understand others. The MDS indicated Resident 1 was dependent (helper does all of the effort) with toileting hygiene and substantial/maximal assistance (helper does more than half the effort) for personal hygiene, shower/bathe self, upper and lower body dressing. The MDS indicated that Resident 1 was dependent for chair/bed-to-chair transfer, tub/shower transfer, and substantial/maximal assist for roll left and right (ability to roll from lying on back to left and right side and return to lying on back on the bed). During an interview on 3/11/2026 at 1:55 p.m. with Registered Nurse (RN) 6, RN 6 stated Resident 1 was initially assessed on 3/2/2026 by RN 4 on 3/2/2026 to have a pressure injury (PI – injury to the skin and underlying tissue resulting from prolonged pressure on the skin) on right buttocks measuring 1.5cm x 1.4 cm x 0.2 cm. RN 6 stated that on the following day on 3/3/2026, she had re-assessed the right buttocks wound and determined it was a MASD, not a PI. RN 6 stated she did not make changes to Resident 1's care plan after she re-assessed the wound to ensure the care plan for Resident 1 is relevant and tailored to resident 1's specific care needs. RN 6 stated that the care plan required revision and that a dedicated care plan addressing MASD should have been established. During an interview on 3/12/2026 at 10:05 a.m. with Director of Nursing (DON), the DON stated that a care plan serves as the guide on how to care for the residents. The DON stated because Resident 1's wound was determined to be different than what was care planned, a care plan for MASD should have been created. The DON stated it is important that care plans are current and updated to reflect the plan of care for the resident's actual condition. 2. During a review of Resident 1's FS, the FS indicated the facility originally admitted Resident 180 on 01/14/2021 and was re-admitted on 8/29/2023. The FS indicated Resident 180 was admitted with diagnosis that included atherosclerotic heart disease (a condition where fat, cholesterol, and calcium found in the blood builds up inside the heart's arteries, causing them to narrow and harden), unspecified psychosis (a condition when a person loses clear signs of losing touch with	F0656	Continued from page 34 for each of these five identified care areas to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of each set-forth protocol is achieved.	

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F0656 SS = E	Continued from page 35 reality but does not fully meet criteria for defined mental illness) and type 2 diabetes mellitus (a chronic condition that affects the way the body processes blood sugar). During review of the H&P report completed on 1/15/2021, the H&P indicated Resident 180 has impaired decision-making capacity. During a review of Resident 180's MDS, dated 2/26/2026, the MDS indicated Resident 180's ability to express ideas and wants was limited to making concrete requests and responds adequately to simple, direct communication only for ability to understand others. The MDS indicated Resident 180 required substantial/maximum assistance with eating and dependent with all other activities of daily living. The MDS indicated that Resident 180 was dependent on all aspects of functional mobility. During a concurrent observation and interview on 3/11/2026 at 8:50 a.m. with Certified Nursing Assistant (CNA) 3 in Resident 180's room, observed Resident 180 had a unique mattress. The mattress was hollowed with cushions built in on the sides raising from the mattress. CNA 3 stated Resident 180's mattress is used to prevent resident from falls. CNA 3 could not state what the mattress is called. During an interview on 3/11/2026 at 9:24 a.m. with RN 6, RN 6 stated Resident 180 has a concave mattress. RN 6 stated that when the interdisciplinary team (IDT) identifies post- fall that sliding out of bed is the reason for the fall, providing concave mattress is part of the intervention implemented to prevent future falls. RN 6 stated a physician order is not required for the concave mattress and that the risk for fall care plan would indicate when a resident has a concave mattress. During a concurrent interview and record review on 3/11/2026 at 9:44 a.m. with Minimum Data Set Coordinator (MDSC) 3, Resident 180's care plan dated 3/11/2026 was reviewed. The care plan did not list the concave mattress as a fall prevention intervention. MDSC 3 stated it should have been in the care plan. MDSC 3 stated the MDSC would have known to add it if he had been present when the intervention was discussed during health care team meeting. MDSC 3 stated he does	F0656		

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JOYCE EISENBERG KEEFER MEDICAL CENTER D/P SNF	7150 TAMPA AVENUE , RESEDA, California, 91335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0656 SS = E	Continued from page 36 not know why the use of concave mattress was not in Resident 180's care plan as a as a fall prevention intervention. MDSC 3 stated he may not have been present during the meeting when it had been discussed for Resident 180 to have concave mattress and it was not communicated to him or another MDSC did not enter it when should have. During a follow-up interview with RN 6 on 3/11/2026 at 11:44 a.m., RN 6 stated she had reviewed Resident 1's records and found the concave mattress was an intervention agreed upon by IDT after Resident 130's fall on 2/5/2021. During a review of Resident 180's "safety Events – Post Accident Assessment and Interventions" dated 2/5/2021, the form indicated based on root cause analysis list interventions added or direct to care plan/s added includes concave mattress...IDT agreed with above interventions". During an interview with the Director of Nursing (DON) on 3/12/2026 at 10:05 a.m., the DON stated agreed upon IDT recommendations should be added to resident's care plan timely. The DON stated that not having the concave mattress in Resident 180's care plan had the potential of having the mattress removed not knowing it is part of Resident 180's plan of care. The DON stated the care plan is the guide for how the health care team takes care of the resident. Every resident should have an individualized comprehensive care plan that is current. During a review of the facility's P&P titled, "Fall Reduction/Prevention Program" last reviewed 4/16/2025, the P&P indicated, "All residents/patients on admission, quarterly, post fall and significant change in condition, will be assessed for fall risk and when such risk is identified , the resident/patient will be noted as a fall risk with appropriate interventions placed in the medical record…Following a resident fall: The IDT, which may include the DON/designee, RN Unit Manager, Social Services, MDS Coordinator, CNA, Charge Nurse and Activities, will review the medical record, pharmacy recommendations and all other factors that may contribute to the resident fall, and create an appropriate, individualized care plan to address each resident's needs and goals with interventions specific to the root cause of the fall".	F0656		

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F0656 SS = E	Continued from page 37 During a review of the facility's P&P titled, "Care Plan - Comprehensive " last reviewed 4/16/2025, the P&P indicated, "An individualized comprehensive care plan that includes measurable objectives and timetables to meet resident/patient's medical, nursing, mental, and psychological needs is developed for each resident/patient… Procedure Each resident/patient's comprehensive care plan has been designed to: a. Incorporate identified problem areas b. Incorporate risk factors associated with identified problems; c. Build on residents/patients' strengths; d. Reflect treatment goals and objectives in measurable outcomes e. Identify the professional services that are responsible for each element of care Care plans are revised as changes in the resident/patient's condition dictate…Care plan goals and objectives are defined as the desired outcome for a specific resident/patient problem. Goals and objectives are reviewed and/or revised: a. When there has been a significant change in resident/patient condition b. When the desired outcome has not been achieved… Using the Care Plan Changes in the resident/patient's condition must be reported to the MDS Assessment Coordinator so that a review of the resident/patient's assessment and care plan can be made… Documentation must be consistent with the resident/patient's care plan 3. During a review of Resident /4's FS, the FS indicated the resident was originally admitted to the facility on 02/06/2020 and readmitted on 08/09/2025 /with diagnoses that included /dementia (a general term for loss of memory, language, problem-solving and other thinking	F0656		

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F0656 SS = E	Continued from page 38 abilities that are severe enough to interfere with daily life) and seizures (a sudden burst of electrical activity in the brain). During a review of Resident /4's MDS, dated 02/06/2026, the MDS indicated the resident`s cognitive skills for daily decision making was severely impaired and /totally dependent on staff for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). The MDS also /indicated /that the resident's activity preferences include listening to music. During an observation on /03/09/2026 /at /1:20 /p.m., /observed /Resident 4 awake in bed and had difficulty expressing herself when spoken to. The television was observed to be off, and there was no music paying in the room. During a concurrent interview and record review /on 03/11/2026 at 8:15 a.m., with Licensed Vocational Nurse 6 (LVN 6) reviewed /Resident 4`s /Care Plan for Activities /dated 02/07/2026 and MDS dated 02/06/2026. LVN 6 stated that the MDS under Section F (identifies resident's preferences about daily routines and activities) indicated music is /especially important /to Resident 4. LVN 6 stated that the /care plan should be resident specific based on the assessment and the resident's needs. LVN 6 stated that a care plan serves as communication tool among the care team to ensure everybody is aware about the resident's specific /activity needs. LVN 6 stated that /the care plan should have addressed the resident's preferred activity of listening to music to ensure the resident's activity needs are met. During a review of the facility`s P&P /titled /"Resident/Patient/Person Centered Care," last reviewed on /4/16/2025, the P&P indicated that /"Person-Centered Care is provided or care planned to meet the /resident comprehensive individual needs as established by the Physician, IDT, and resident and/or responsible party, which provides /the highest reasonable and feasible psychosocial well-being and overall health of the resident…" 4. During a /review of Resident /72's FS, the FS /indicated /the facility admitted the resident	F0656		

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F0656 SS = E	Continued from page 39 on /2/17/2026 /with diagnoses including /unspecified /severe sepsis /(a life-threatening blood infection) /and /Parkinson's /disease /(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident /72's /H&P dated /12/10/2025, the H&P /indicated /Resident /72 /speaks in full sentences, was able to make her /own needs known and able to make /simple /medical decisions. During a /review of Resident /72's MDS, the MDS indicated /Resident /72 /usually makes herself understood and usually understands others. The MDS further /indicated /Resident /72 /needs /substantial /assista nce /with /upper body and lower /dressing, personal hygiene /and putting on and taking off shoes. During a review of the facility provided matrix (A /list /of residents /combined with a checklist that /identifies /who has specific care needs /such as TBP) on 3/9/2026, the matrix indicated Resident 72 was identified as being placed on TBP. During a review of Resident 72's Clostridioides difficile (C.diff /-a bacteria /that causes severe diarrhea and intestinal inflammation) test results dated 3/6/2026, the test results /indicated /Resident 72 tested positive for C.diff /toxins (harmful substance that C. diff produces) and required the resident to be placed on contact isolation (infection control measures to prevent the spread of germs passed by direct or indirect touch). During /review /of Resident 72's care plans on 3/9/2026 at 9:05 a.m., there was no care plan addressing TBP. During a concurrent interview /record review /on /3/12/2026 /at /2:28 /p.m., /with the DON, the DON /stated /care plans are /basically a /manual of specific care for each individual resident. The DON /stated /licensed staff /must create an individualized care plan /when there is a change of condition such as /C. Diff /requiring TBP for Resident 72. /The DON /stated /the care plan should have been completed on 3/6/2026 when the resident tested positive for C. diff so staff would know how to care for the resident and prevent the spread of infection.	F0656		

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F0656 SS = E	Continued from page 40 During a /review of the facility's P&P /titled, /"Resident/Patient/Person Centered Care," last reviewed on /4/16/2025, the P&P indicated that /"Person-Centered Care is provided or care planned to meet the /resident comprehensive individual needs as established by the Physician, IDT and resident and/or responsible party, which provides /the highest reasonable and feasible psychosocial well-being and overall health of the resident…" 5. During a review of Resident 81's FS the FS indicated the facility originally admitted Resident 81 on 6/29/2023, with diagnoses including: vascular dementia (loss of cognitive functioning-thinking, remembering, and reasoning), psychosis (a mental health symptom involving a loss of contact with reality) and major depressive disorder (a mental health condition that causes a persistently low or depressed mood and a loss of interest in activities that once brought joy). During review of Resident /81's MDS, dated /12/17/2025, the MDS indicated Resident /81 /has severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and /is dependent /for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During /a /concurrent /interview /and record review /on 3/12/2026 at 12:10 /pm with RN 3, /Resident 81's care plan titled, "Behavioral symptoms related to Seroquel," dated 8/11/2025 was reviewed. /The care plan /indicated /to monitor side effects of Seroquel including orthostatic hypotension (a significant drop in blood pressure when measuring orthostatic blood pressures). /RN 3 stated /orthostatic blood pressures can be done for /Resident 81. Resident /81 mostly lies /in bed but /can /be placed in a reclining wheelchair /to /obtain orthostatic blood /pressure. /RN 3 /stated /there is no documentation /indicating /why orthostatic blood pressure could not be done and /there is no care plan to /indicate /how to /properly measure /Resident 81's /orthostatic /blood pressure. Resident 81's further stated orthostatic blood pressure /has /only been measured once since the Care plan was /initiated /on 8/11/2025. During an interview on 3/12/2026 at 2:00 pm with the	F0656		

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F0656 SS = E	Continued from page 41 DON, /the DON /stated /an individualized care plan for measuring orthostatic blood pressure should have been created and implemented for Resident 81. /The DON /stated /repeated inability to measure /orthostatic blood pressure should have been reported so that the care plan could be individualized and give proper interventions to /monitor /for orthostatic hypotension. During a review of the facility's P&P titled, "Care Plans – Comprehensive," reviewed 4/2025, the P&P indicated, "when goals and objectives are not achieved, the resident/patient's clinical record will be documented as to why the results were not achieved and what new goals and objectives have been established. Care plans will be /modified /accordingly." The P&P also /indicates /that it is the responsibility of the Certified Nursing Assistants (CNA) to report /to the nurse supervisor when care plan goals and /objectives /have not been achieved.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657	F-657 Corrective Action for Affected Residents: On 3/12/2026, the Director of Nursing (DON) or designee reviewed Resident 94's care plan titled "Episodes of refusing insulin" and revised it to include resident-specific interventions addressing insulin refusals. The revised care plan now includes: parameters for physician notification after two consecutive insulin refusals. On 3/12/2026, the RN Unit Manager notified Resident 94's attending physician regarding the pattern of insulin refusals documented on 3/1/2026, 3/4/2026, 3/5/2026, 3/6/2026, 3/7/2026, and 3/9/2026 to obtain guidance and review alternative treatment options. Licensed nursing staff were in-serviced by the DON or designee on the revised care plan interventions for Resident 94, including when to notify the physician, documentation requirements, and individualized approaches for medication administration. Identifying other Residents having the Potential to be Affected: On 3/25/2026, the Medical Records Manager identified residents with orders for insulin by reviewing Medication Administration Records (MARs) for the previous 30 days. The RN Unit Manager or designee reviewed the resident's record and no other residents were found to refuse insulin. Measures put into place or Systemic Changes: On 3/27/2026, the DON, Chief Compliance Officer and Administrator reviewed the facility policy and procedure titled "Care Plans, Comprehensive" with no changes. The DON or designee in-serviced the licensed	04/11/2026

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F0657 SS = D	Continued from page 42 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the interdisciplinary team (IDT- a collaborative approach where healthcare professionals from various disciplines work together to provide comprehensive patient care) reviewed and revised a resident's care plan to include appropriate interventions addressing the resident's refusal of prescribed insulin injections for one of two (Resident 94) sampled residents. This deficient practice had the potential to result in failure to deliver the necessary care and services to Resident 94. Findings: During /a /review of Resident /94's /Face Sheet, the /Face Sheet /indicated the facility originally admitted Resident 94 on 10/01/2023 and re-admitted resident on 1/12/2025, with diagnoses including diabetes mellitus (DM-a chronic condition that affects the way the body processes blood sugar [glucose]), with diabetic polyneuropathy (nerve damage caused by diabetes that makes feet or hands feel numb, tingly, or painful), mild cognitive impairment(mild thinking or memory problems) of uncertain or unknow etiology (illness), and peripheral vascular disease(a condition where blood vessels outside heart and brain usually in legs become blocked or narrowed, causing poor blood flow). During a review of Resident 94's History and Physical (H & P) dated 2/27/2026, the H&P /indicated /Resident 94 does have the capacity to understand and make decisions on her own. During a review of Resident /94's Minimum Data Set /(MDS – a resident assessment tool), dated /1/02/2026, /the MDS indicated Resident 94's cognition (relating to or involving the processes of thinking and reasoning) /is intact. During a review of Resident 94's Care Plan (CP) updated	F0657	Continued from page 42 nurses on the policy requirements for developing resident-specific care plan interventions when residents refuse medications, emphasizing the importance of including clear parameters for physician notification and individualized approaches. The in-service included case study examples and review of documentation expectations. The in-service included recognizing patterns of medication refusals that require care plan revision and physician notification, including how to document refusal attempts with sufficient detail to support individualized care planning, review of clinical parameters requiring immediate physician notification and the difference between isolated refusals versus established patterns. The "Stand Up Meeting Routine Questionnaire" checklist was revised to include a standing section for reviewing residents with patterns of medication refusals to ensure timely discussion and care plan revision by the IDT. Plan to Monitor Performance: Beginning 4/6/2026, and continuing for eight weeks, the MDS Coordinator will conduct weekly audits of five residents who have care plans addressing medication refusals to ensure the care plans include resident-specific interventions with clear parameters for physician notification. Beginning 4/6/2026 and continuing for eight weeks, the MDS Coordinator or designee will conduct weekly reviews of Medication Administration Records (MARs) for 10 residents receiving insulin or other critical medications to identify any patterns of refusals and verify that licensed nursing staff notified the physician according to care plan parameters and that the care plan was revised as appropriate. Any deficiencies identified through monitoring will be addressed immediately with the responsible staff member, and re-education will be provided as needed. The MDS Coordinator or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0657 SS = D	Continued from page 43 on 1/6/2026 titled "Episodes of non-compliant with medications-insulin," the CP goal indicated the resident will participate in tasks and demonstrate a level of compliance that does not interfere with quality of care needed to maintain the safety and well-being of the resident. The CP indicated the following interventions: - Break into small steps, be patient and allow ample time or try again later. Simplify the request. Ask yes/no questions. Respect request for privacy. Reassure, comfort and distract when appropriate. Provide explanation as to benefits and risks for treatment/medication/plan of care. - Review what constitutes compliance/best interests. - Allow for time to review information given and ask if there is a better time/another day this can be reviewed again. Involve family/significant others as needed. -Accept/support decision to refuse/deny care. -Notify the primary physician of decision and review options if available. (unchecked) During a review of Resident 94's Physician Order Report dated 3/1/2026 to 3/10/2026, the Physician Order Report indicated the following order, with the start date of 3/21/2025. -Novolog(fast acting insulin) insulin 8 units; subcutaneous (under skin) for DM ; please rotate the site, hold if blood sugar less than 100 milligrams per deciliter(mg/dl, a unit of measurement to indicate how many milligrams of as glucose are present in one deciliter [100 /mL] of blood), once a day, 7:30 a.m. During a review of Resident 94's Medication Administration Record (MAR) dated 3/01/2026 to 3/10/2026, the MAR indicated the following results for the Novolog 8 units subcutaneous order administered once daily at 7:30 a.m.: • 3/1/2026 at 7:20 a.m. – Not Administered: Refused • 3/4/2026 at 8:35 a.m. – Not Administered: Refused • 3/5/2026 at 8:22 a.m. – Not Administered: Refused • 3/6/2026 at 7:15 a.m. – Not Administered: Refused	F0657		

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F0657 SS = D	Continued from page 44 • 3/7/2026 at 7:58 a.m. – Not Administered: Refused • 3/9/2026 at 8:04 a.m. – Not Administered: Refused During a concurrent interview and record review on 3/10/2026 at 1:02 p.m., with the Director of Nursing (DON), Resident 94's Physician Order Report dated 3/01/2026 to 3/10/2026 was reviewed. The DON stated the order indicated that /Resident 94 should receive insulin Novolog 8 units every morning at 7:30 a.m. The DON stated Resident 94 has a tendency to refuse insulin injections. During a concurrent interview and record review on 3/10/2026 at 1:22 p.m., with the DON Resident 94's CP titled "Episodes of non-compliant with medications-insulin," dated 1/6/2026 was reviewed. The DON stated Resident 94's care plan was not resident specific as it lacked critical information related to the resident's refusal. The DON stated the CP did not include parameters for escalation such as the number of missed doses requiring notification, the frequency for monitoring refusals, or defined blood sugar levels that would require physician notification. The DON further stated that the section indicating "notify physician of decision and review options if available" was unchecked, indicating this intervention had not been incorporated into the resident's CP. During a concurrent interview and record review on 3/10/2026 at 1:32 p.m., with the DON Resident 94's IDT/Care Plan with observation date of 1/6/2026 and completion date of 3/10/2026, was reviewed. The DON stated the IDT meeting care plan review did not address Resident 94 's repeated refusals of insulin administration. The DON also stated that this issue should have been discussed during the IDT/Care Planning meeting to establish appropriate interventions. During a concurrent interview and record review on 3/12/2026 at 8:22 a.m., with Licensed Vocational Nurse (LVN) 4, Resident 94's CP titled "Episodes of non-compliant with medications-insulin," dated 1/6/2026 was reviewed. LVN 4 stated that /Resident 94's care plan was not resident specific, as the CP did not indicate when the physician should be notified, the number of refusals requiring notification, and acceptable blood glucose parameters. LVN 4 stated she believed the physician should be notified after three refusals.	F0657		

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F0657 SS = D	Continued from page 45 During a /review of the facility's policy and procedure (P&P) titled, "Inter-disciplinary Risk meeting," revised on /4/16/2025, the P&P indicated /the Risk meeting is designated to bring current resident/patient care issues to the Interdisciplinary Team (IDT) for discussion, potential alterations to the plan of care, notification to all disciplines regarding current status of residents/patients, and to develop proactive approaches designed to prevent acute episodes from occurring. During a /review of the facility's P&P titled, "Care Plans, Comprehensive," revised on /4/16/2025, the P&P /indicated /an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident/patient's medical, nursing, mental and psychological needs is developed for each resident/patient. Our facility's care planning/interdisciplinary team, in coordination with the resident/patient his/her family or representative (sponsor), develops and maintains a comprehensive car plan for each resident. Each resident/patient's comprehensive care plan has been designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident/ patient's strengths; d. Reflect treatment goals and objectives in measurable outcomes; e. Identify the professional services that are responsible for each element of care;	F0657		
F0686 SS = D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with	F0686	F-686 Corrective Action for Affected Residents: The RN Unit Manager obtained a physician order to determine the appropriate setting for Resident 4's low air loss mattress (LALM) based on Resident 4's current weight of 171 pounds. The LALM setting was adjusted from 210 pounds to the appropriate setting per physician order on 03/11/2026. On 03/24/2026, Registered Nurse (RN) 6 completed a comprehensive skin assessment as a late entry for	04/11/2026

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYCE EISENBERG KEEFER MEDICAL CENTER D/P SNF	7150 TAMPA AVENUE , RESEDA, California, 91335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0686 SS = D	Continued from page 46 professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to: 1.Clarify with the physician the basis for determining the appropriate setting for a resident's low air loss mattress (LALM – designed to distribute a patient's body weight over a broad surface area and help prevent skin breakdown) in accordance with the facility policy for one (Resident 4) out of two sampled resident investigated for pressure ulcer/injury (a skin and soft tissue injury that occurs when skin is under pressure). This deficient practice placed the resident at risk of discomfort and development of new pressure ulcers (areas of damaged skin and tissue caused by sustained pressure /that reduces blood flow to vulnerable areas of the body). 2. Complete /a /skin /assessment /for one of two sampled residents /(Resident 1) /reviewed for pressure ulcer/injury when Resident 1's skin /impairment was re-classified /from /Stage 2 pressure /injury /(PI /– /injury /to the skin and underlying /tissue resulting from prolonged pressure on the skin) /to Moisture /Associate /Skin /Damage (MASD /– /skin erosion /caused by prolonged exposure to source of moisture such /as urine, stool, seat, wound drainage, saliva or mucus). This deficient practice /had the potential to /place Resident 1 at risk /for inappropriate /interventions, incorrect /treatment, and potential worsening of /skin integrity. Findings: 1.During a review of Resident 4's Face Sheet, the Face	F0686	Continued from page 46 Resident 1's right buttocks wound and documented the findings in the Wound Management form and Progress Notes, confirming the wound classification as Moisture Associated Skin Damage (MASD) and verifying alignment with current treatment orders dated 03/03/2026. Identifying other Residents having the Potential to be Affected: Medical Records Manager provided a list of 6 additional residents currently utilizing LALM. The RN Unit Managers audited and made corrections to ensure the setting is appropriate based on the residents' current weight. For residents with LALM orders that do not specify the basis for the setting, the RN Unit Manager or designee ensured that clarification was obtained from the physician. The RN Unit Managers initiated a review of residents with known skin changes within the past 30 days to verify that comprehensive skin assessments were completed and documented when wounds were re-classified or re-assessed. The MDSC will ensure a care plan was completed. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced Licensed nurses on the need to obtaining physician orders that specify the basis for determining appropriate LALM settings according to resident current weight and manufacturer guidelines. The in-service included review of the Air Loss Mattress Operation Manual and the requirement to adjust settings based on the resident's current weight or healthcare professional recommendation. The DON and/or Director of Education in-serviced Licensed nurses on the facility policy and procedure titled "Wound and Skin Management" with emphasis on the responsibility to complete and document comprehensive skin assessments when skin impairments are identified, re-assessed, or re-classified. The in-service included instruction on differentiating between pressure injury and MASD, documenting all assessment findings including wound measurements, characteristics, staging, drainage, and the basis for any change in wound classification. The "Stand Up Meeting Routine Questionnaire" was updated verify documentation is in place when skin impairments are identified, re-assessed, or re-classified. Plan to Monitor Performance: The RN Unit Manager will audit resident who are utilizing LALM to verify that physician orders specify the basis for determining the appropriate mattress setting and that the LALM is set according to the resident's current weight or physician	

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F0686 SS = D	Continued from page 47 Sheet indicated the facility originally the resident to the facility on 02/06/2020 and readmitted on 08/09/2025 with diagnoses that included dementia (/a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) and seizures (a sudden burst of electrical activity in the brain). During a review of Resident 4`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 02/06/2026, indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and totally dependent on staff for activities of daily living (activities that are fundamental to survival and well-being and include things like eating, bathing, dressing, and toileting). During an observation on 03/09/2026 at10:49 a.m., observed Resident 4 in bed sleeping on a low air loss mattress set at 210 pounds. During a concurrent interview and record review on 03/11/2026 at 8:32 a.m., with Licensed Vocational Nurse 6 (LVN 6), Resident 4`s physician`s order and current weight was reviewed. The review indicated that there was an order for a LALM for wound prevention on 3/6/2026, however it did not specify the basis for determining the setting for the LALM. LVN 6 stated Resident 4's current weight is 171 pounds (lbs.-unit of weight). LVN 6 stated that the LALM is used for skin management and to prevent skin breakdown for resident that are always in bed. LVN 6 stated a LALM is set according to the resident`s weight and the higher the setting the harder and firmer the mattress becomes, which can potentially result in the development of a wound. During a concurrent observation and interview on 3/11/2026 at 8:45 a.m., in Resident 4's room with LVN 6, observed Resident 4 lying on a LALM set at 210 lbs. LVN 6 stated that the setting of 210 lbs. is not accurate and she will obtain a physician order to determine the appropriate setting for Resident 4's LALM. During an interview on 03/12/2026 at 9:08 a.m., with the DON stated the use of air loss mattress can prevent	F0686	Continued from page 47 recommendation. The Medical Records Consultant will conduct random audits of five residents per month with documented skin impairments to verify that comprehensive skin assessments are completed and documented when wounds are initially identified, re-assessed, or re-classified, that treatment orders align with documented assessments, and care plans are in place. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0686 SS = D	Continued from page 48 the development of skin impairment and if the setting is incorrect, it will not achieve the intended therapeutic effect but rather can be the cause of the pressure ulcer. During a review of the facility`s policy and procedure (P&P) titled “Patient/Resident Pressure Redistribution Devices-Air Loss Mattress,” last reviewed on 4/16/2025, the P&P indicated that “it is the policy of this facility that all residents/patients utilizing an air loss mattress will be monitored appropriately to ensure pertinent and effective use and cleaning…” During a review of the Air Loss Mattress “Operation Manual (OM)” provided by the facility, the OM indicated that users can adjust air mattress to a desired firmness according to patient`s weight or the suggestion from a health care professional…”. 2. /During a review of Resident 1’s /Face Sheet, the /Face Sheet /indicated /the facility admitted Resident 1 to the facility on /01/10/2026, with diagnoses including /bacterial pneumonia (serious lung infection /caused by /bacteria), /chronic respiratory failure /(long-term condition where the lungs cannot sufficiently transfer oxygen into the blood) and /type 2 diabetes mellitus /(a chronic condition that affects the way the body processes blood sugar). During review of the History and Physical (H&P) report completed on /1/13/2026, the H&P /indicated /Resident /1 /is able /to /make her own needs known and /has the capacity to /make her own medical decisions. During a review of Resident 1’s MDS dated /2/26/2026, the MDS indicated Resident 1 /is /able to /make self-understood and able to understand others. The MDS indicated Resident 1 was dependent (helper does /all of /the effort) with /toileting hygiene /and substantial maximal /assistance /(helper does more than half the effort) /for /personal hygiene, /shower/bathe self, upper and lower body dressing. The MDS indicated that Resident /1 /is dependent for /chair/bed-to-chair transfer, tub/shower transfer, /and substantial/maximal assist /for /roll left and right (ability to roll from laying on back to left and right /side and /return to laying on back on the bed).	F0686		

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F0686 SS = D	Continued from page 49 During an interview on 3/9/2026 at 9:46 a.m. with Resident 1, /Resident 1 /stated /she /has /bowel and bladder incontinence /(losing control over passing stool or urine, leading to /accidental leakage). /Resident 1 /stated that her medication makes her urinate often, and she had several days of diarrhea. Resident 1 /stated /that the /frequent urination and /recent /loose stools have /caused her /to have sores on her buttocks. During a concurrent interview and record review on /3/11/2026 at /12:50 p.m., with /the Minimum Data Set /Coordinator /(MDSC) 1, Resident /1's "Wound Management" dated /3/2/2026, "Progress Notes" dated 3/2/2026-3/3/2026, and /"Physician /Orders" /dated 3/11/2026 were reviewed. /MDSC 1 /stated /that it is the /Registered /Nurse's (RN) responsibility to perform a comprehensive skin assessment during admission and as needed, such as when a resident develops impaired skin integrity. /During review of /the /"Wound Management" /form /dated 3/11/2026, /the form /indicated /Resident 1 had a /pressure injury to right buttocks /measuring 1.5 centimeters (cm-unit of measurement) x 1.4 cm x /0.2 cm. /During review of /Resident 1's current /treatment orders, /the /physician's orders /dated 3/3/2026 /indicated /treatment orders /for /MASD /to the right buttocks. MDSC 1 /stated /that /the wound was /likely re-assessed /and /determined to be MASD and not a PI. MDSC1 /stated that /there /was /no documented evidence that an assessment was completed by an RN on the "Wound Management" or on the progress notes from 3/2/2026-3/3/2026 /indicating /presence of /right buttocks /MASD. During /an /interview on /3/11/2026 at /1:55 p.m. with /RN /6, /RN 6 /stated /she had re-assessed Resident 1's /right buttocks wound on 3/3/2026 and determined the wound was /MASD, /not /PI. /RN 6 /stated /she did not /document /her assessment when /she re-evaluated the wound. RN 6 /stated /she /should have documented /the assessment because if she /did not document it, there is no /way that it can be /validated /the re-assessment /was performed. During an interview on 3/12/2026 at 10:05 a.m. with the Director of Nursing (DON), the DON stated that /newly identified skin impairment /may be /at times be /re-assessed the following day by another /RN /with greater wound care experience. /The DON /stated /that the /RN who conducted the reassessment is responsible for /documenting their findings. The DON /stated /that if	F0686		

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F0686 SS = D	Continued from page 50 the re-assessment is not documented, it is considered as though it was not performed. /The /DON /stated /that /because Resident 1's wound re-assessment was not recorded, the health care team lacked awareness of any changes from the /initial /evaluation of the right buttocks wound dated 3/2/2026 to 3/3/2026. Without documentation confirming the wound /was /MASD, the prescribed treatment /did not /align with the skin assessment. The DON /stated /discrepancy /between assessment and treatment can /potentially /result in /delaying /appropriate wound /healing due to the absence of /appropriate /intervention. During a concurrent observation and interview on 3/13/2026 /at 10:40 a.m. with Licensed Vocational Nurse (LVN) /1, /Resident 1's buttocks /was /observed /to have /irregular /areas of skin /epidermal skin erosion on the buttocks. /LVN 1 /stated /that /Resident /1's skin /impairment /is MASD and treatment orders for /Resident 1's buttocks /is for MASD. During a review of the facility's P&P titled, "Wound and Skin Management" last reviewed /4/16/2026, the P&P /indicated: "1. /Licensed nurse/treatment nurse will document injury status and other skin conditions at least every /seven (7) days and prn and should cover each of the following areas: Licensed nurse shall differentiate the type of injury (pressure-related or non-pressure related) Licensed nurse/treatment nurse shall document status of the injury sites, treatments administered, status of dressing if ordered, /and effectiveness of treatment and signs and symptoms of infection Describe injury edges and wound bed, share, surrounding tissues, drainage (color and odor) Size: be sure to include length, width, and depth measurements in centimeter Stage the pressure injury/sore Drainage Undermining/tunneling	F0686		

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F0686 SS = D	Continued from page 51 Character of wound Pain assessment and changes in condition /e.g. /infection or other /possible complications During a review of the facility's /Health Information Record Manual /titled, "Chapter III 3025 Documentation Guidelines" last reviewed /4/16/2025, the /record /indicated, /"3. /Documentation in the legal health record will follow /these basic rules: …Record applicable observations, /psychosocial and physical manifestations, incidents, unusual occurrences, and abnormal behavior…Promptly record /as the events or observations occur; complete, concise, descriptive, factual, and accurately describe services provided /to/for the resident… /"	F0686		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to: 1.Ensure one of five sampled residents (Resident 40) reviewed for accidents, was safely transferred from bed to wheelchair using the sit-to-stand lift (Sara lift, a mechanical device that helps lift a resident to rise from a seated position. This requires a resident to be able to support at least partial body weight while standing) with a two-person assist in accordance with the facility policy. This deficient practice had the potential to place Resident 40 at risk for fall.	F0689	F-689 Corrective Action for Affected Residents: On 3/12/2026, Resident 40 did not sustain any injury during the transfer using the Sara lift. The Night shift RN Supervisor and the DON re-educated Certified Nurse Aide 4 (CNA 4) on the facility policy requiring two-person assist for all transfers using the Sara lift. On 3/12/2026, the RN Unit Manager reviewed Resident 40's transfer needs and care plan to ensure all interventions were current and appropriate. Identifying other Residents having the Potential to be Affected: On 4/1/2026, the RN Supervisors identified residents who require Sara lift transfers or other mechanical lift devices by reviewing current physician orders and care plans. The night shift RN Unit Managers audited transfer practices for these residents to ensure transfers were being completed in accordance with physician orders, care plans, and facility policy requiring appropriate staffing levels for safe transfers. Out of 22 transfers observed, 3 were not in compliance by one C.N.A. C.N.A was formally educated by the RN Supervisor and will be continued to be monitored to ensure they follow safe transfer expectations. Any further non-compliance will be addressed by DON and HR for further action. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced licensed nursing staff and certified nurse aides on the facility policy titled 'Moving/Positioning a resident/patient' with emphasis on the requirement for two-person assist when using Sara lifts and Hoyer lifts. The in-service included safe transfer techniques, the risks associated with single-person transfers using mechanical lifts,	04/11/2026

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F0689 SS = D	Continued from page 52 2. Ensure prepared medication was not left unattended on one of five medication carts (Medication Cart 2). This deficient practice had the potential to result in accidental ingestion of medication and can lead to adverse reactions (any unexpected or dangerous reaction to a drug). Findings: 1. During a review of Resident 40's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on 3/16/2021 and re-admitted on 1/03/2026 with diagnoses that included dysphagia (difficulty swallowing), attention to gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 40' s Minimum Data Set (MDS, a resident assessment tool), dated 1/01/2026, the MDS indicated Resident 40 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 40 was dependent (helper does all the effort) on staff for chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). During a review of Resident 40's Physician's Orders, the orders indicated: Sara lift with two-person assist (sic) [a Latin adverb that is used to note when a quotation may not be correct in terms of spelling or grammar] on all transfers, dated 11/20/2024. During a review of Resident 40's Care Plan for Falls, initiated 3/19/2021, the care plan indicated a goal that there will be a reduced risk for falls daily for 90 days. The care plan indicated an intervention for Sara lift with two-person assist on all transfers. During a review of Resident 40's Falls Risk Assessment, dated 12/31/2025, the assessment indicated the resident was at a high risk for falls.	F0689	Continued from page 52 and the importance of following physician orders and care plans. By 4/6/2026, the DON or designee will implement a process requiring licensed nursing staff to conduct random observations of transfers using mechanical lifts to ensure compliance with two-person assist requirements. Plan to Monitor Performance: The "Weekly QAPI Data Collection" tool was updated to include requirement for RN Unit Managers and/or RN Supervisors to conduct weekly audits of a sample of residents requiring mechanical lift transfers. The audit will include observation of transfers to ensure two-person assist is being utilized as ordered and documented in the care plan. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. Date of Compliance: 4/2/26 Corrective Action for Affected Residents: On 3/9/2026, the prepared medication left unattended on Medication Cart 2 was immediately secured by Licensed Vocational Nurse 8 (LVN 8) and administered to the intended resident. Identifying other Residents having the Potential to be Affected: On 3/9/2026, the RN Unit Managers conducted observations of medication passes on other floors of the facility to identify whether other prepared medications were left unattended on medication carts or in unsecured locations and none were observed. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced licensed nursing staff on the facility policies titled 'Medication Administration,' with emphasis on the requirement that medications must not be left unattended on medication carts, medications must be administered immediately after preparation, and medications must be kept in locked carts or rooms accessible only to licensed personnel. The in-service will include the risks of leaving prepared medications unattended, including potential for accidental ingestion by other residents and adverse reactions. The in-service also addressed appropriate actions to take if interrupted during medication pass, including securing prepared medications in the locked medication	

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F0689 SS = D	Continued from page 53 During an observation on 3/12/2026 at 7:30 a.m., observed CNA 4 opening Resident 40's room door and exiting pushing a Sara lift. CNA 4 stated she moved Resident 40 from bed to wheelchair with the Sara lift. When asked if she had assistance with the transfer from another staff member, she stated Registered Nurse 5 (RN 5) assisted her. During an interview with RN 5 on 3/12/2026 at 7:37 a.m., she stated she did not help CNA 4 with any task that morning as she walked in the hallway and stopped in front of Resident 40's room. CNA 4 stated RN 5 assisted her with the Sara lift and RN 5 stated she did assist CNA 4. When asked why RN 5 stated she had helped CNA 4 when a moment ago she said she did not help her, RN 5 stated she did not help CNA 4 to transfer Resident 40 from bed to wheelchair using the Sara lift. Then CNA 4 stated she used the Sara lift by herself without help from any staff. CNA 4 stated she should have asked another staff member to help her because it is important for someone to be standing by to ensure the Sara lift is locked and the wheelchair does not move. RN 5 stated two staff should operate the Sara lift, to ensure the safety of the move and to prevent injury. RN 5 stated one person transfer with the Sara lift could place a resident at risk for fall. During a concurrent interview and record review with the Director of Nursing (DON) on 3/12/2026 at 8:15 a.m., the DON reviewed the facility's policy and procedure titled, "Moving/Positioning a resident/patient," last reviewed 4/16/2025. The DON referred to the portion of the policy that indicated: to ensure that there is a second person to assist in the use of Hoyer lifts (electric medical device designed to safely transfer individuals with limited mobility between beds, chairs, and wheelchairs, which would include Sara lift). The DON stated this referred to a Sara lift also. The DON stated the Sara lift should always have two staff members present for resident transfer. The DON stated it is their policy, for safety, to prevent any possible injury. During a review of the facility's policy and procedure titled, "Moving/Positioning a resident/patient, last reviewed 4/16/2025, the policy indicated in the section titled, "Hoyer/Sara Lifts: "Ensure that you have a second person to assist in the use of Hoyer lifts." 2. During an observation on 3/9/2026 at 9:19 a.m. in	F0689	Continued from page 53 cart if an emergency arises. The "Weekly Quality Data Collection" form was updated to include random observations by the RN Unit Managers or RN Supervisors during medication passes to ensure licensed nursing staff are following proper medication security procedures. Plan to Monitor Performance: The RN Unit Managers and/or RN Supervisors will conduct weekly random observations during medication passes on each floor of the facility during different shifts to ensure prepared medications are not left unattended on medication carts or in unsecured locations. The observations will verify that licensed nursing staff are administering medications immediately after preparation and securing medication carts when not in immediate use. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYCE EISENBERG KEEFER MEDICAL CENTER D/P SNF	7150 TAMPA AVENUE , RESEDA, California, 91335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0689 SS = D	Continued from page 54 between the nursing station and main dining room on the second floor of the facility, a medication cup filled with pasty substance and a spoon inside the cup was observed resting on the unattended Medication Cart 2. During an interview on 3/9/2026 at 9:30 a.m. with Licensed Vocational Nurse 8 (LVN 8), LVN 8 stated she prepared the medication for a resident and left it on the medication cart when she went to another resident's room. LVN 8 stated she left the medication on the cart so she could inform another resident about their upcoming beauty salon visit later that day. LVN 8 stated there was no urgent need to let the resident know about her visit to the beauty salon. LVN 8 stated she should not have allowed herself to get distracted and be interrupted from administering the medication she had prepared for the resident. LVN 8 stated "I know my mistake. We have to only be doing medications when doing medications." LVN 8 stated she was multi-tasking when she should be concentrated on medication pass (a structure process used in long-term facilities to ensure residents receive their medication safely and accurately). LVN 8 stated medication should be administered immediately after preparation. LVN 8 stated that if there was a valid reason that interrupts her during medication pass such as an emergency, the medication must be stored securely to prevent access by other residents for safety reasons. During an interview on 3/12/2026 at 10:05 a.m. with the DON, the DON stated medication should never be left unattended due to the potential risk of other residents ingesting medication not prescribed for them. The DON stated medications must be securely maintained to protect resident safety. During a review of the facility's P&P titled, "Medication Administration" last reviewed 4/16/2026, the P&P indicated "Security of medication care during medication pass: No medication are kept on top of the cart". During a review of the facility's P&P titled, "Drug Storage/Inventory Inspection" last reviewed 4/16/2026, the P&P indicated "Drugs on the unit will be kept in locked medication carts or in locked medication rooms with access to licensed nursing and pharmacy personnel only…Drugs shall be accessible only to licensed personnel designated by the medical center".	F0689		

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F0689 SS = D	Continued from page 55 During a review of the facility's P&P titled, "Accident and Resident Safety Reporting" last reviewed 4/16/2026, the P&P indicated "The facility provides management to support environment, training, assessment and action(s) planned as needed to keep residents as free as possible from accidents, hazards, breaches of personal identified information, infections, communicable/pandemic diseases over which the facility has control…Hazards refer to elements of the residents environment that have the potential to cause injury or illness…Free of accidents hazards as is possible refers to being free of accident hazards over the facility has control…Resident environment includes the physical surrounding to which the resident has access (e.g. room, unit, common areas, and facility grounds, etc.)".	F0689		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to complete a resident's Hemodialysis (HD, the removing of waste and excess fluid to prevent build up in the body for residents who have loss of kidney [organs that remove waste products from the blood and produce urine] function) Record with information including assessment of the arteriovenous fistula (AVF- a surgically created connection, typically between an artery and a vein in the forearm or upper arm, with the non-dominant arm preferred) for bruit and thrill (you can feel for a thrill at the fistula incision site. A thrill feels like buzzing under your skin. The /bruit and thrill /tell you that your fistula is working) for one of one (Resident 16) resident investigated under the Dialysis care area. This deficient practice placed the resident at risk for complications such as thrombosis (blood clot), stenosis (narrowing), or reduced blood flow, resulting in loss of access, infection, and inadequate dialysis treatment.	F0698	F-698 Corrective Action for Affected Residents: On 03/11/2026, the Director of Quality reviewed Resident 16's Hemodialysis Record and ensured that Licensed Nurses began documenting the assessment of the arteriovenous fistula (AVF) for bruit and thrill before and after each hemodialysis treatment. The Director of Quality educated the licensed nurses who directly care for the two in-house residents on dialysis on 3/17/26 and 3/20/26. The Director of Quality audited Resident 16's subsequent Hemodialysis Records to ensure assessments of the AVF for bruit and thrill were documented before and after each dialysis treatment session 4/1/26. Identifying other Residents having the Potential to be Affected: Only two residents are receiving hemodialysis treatment at this time. Measures put into place or Systemic Changes: On 03/30/2026, the Director of Quality revised the "Hemodialysis Record" form to include clearly designated fields for pre-dialysis and post-dialysis AVF assessment documentation, including specific checkboxes for bruit and thrill assessment. The DON and/or Director of Education in-serviced licensed nursing staff on the importance of assessing and documenting the AVF for bruit and thrill before and after each dialysis treatment, signs and symptoms of AVF complications including thrombosis, stenosis, reduced blood flow, and infection, the facility policy and procedure titled "Dialysis Care," and proper completion of the revised "Hemodialysis Record" form. Plan to Monitor Performance: The Director of Quality will conduct weekly audits of Hemodialysis Records for	04/11/2026

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F0698 SS = D	Continued from page 56 Findings: During a review of Resident 16's Face Sheet, the Face Sheet indicated the facility originally admitted the resident to the facility on 08/20/2025 with diagnoses including end stage renal disease (when kidneys no longer function well enough to meet a body's needs) and type 2 Diabetes Mellitus (when the body cannot use insulin correctly and sugar builds up in the blood). During a review of Resident 16`s Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 02/25/2025, the MDS indicated the resident`s cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was severely impaired and the resident required supervision and touching assistance (helper provides verbal cues) for oral hygiene, upper body dressing, personal hygiene and substantial/maximal assistance (helper does more than half the effort for toileting hygiene and shower. During a review of Resident 16's Physician Order dated 02/11/2025 to 03/11/02025, the Physician Order indicated an order for dialysis every Tuesday-Thursday-Saturday at 11:30 a.m. chair time (refers to the time spent sitting in a dialysis chair during a dialysis treatment, which /typically lasts around 3–4 hours). During a review of Resident 16`s "Hemodialysis Record" on 03/11/2026 at 10:11 a.m. with Licensed Vocational Nurse 6 (LVN 6), the record did not have documented evidence that an assessment for the presence of bruit and thrill was conducted on the following dates: 02/03/2026 02/05/2026 02/07/2026 02/09/2026 02/12/2026 02/14/2026 02/17/2026	F0698	Continued from page 56 all residents receiving hemodialysis to ensure that documentation before and after each dialysis treatment is complete and accurate. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0698 SS = D	Continued from page 57 02/19/2026 02/21/2026 02/24/2026 02/26/2026 02/28/2026 LVN 6 stated that the AVF must be assessed before and after dialysis treatments to ensure that the fistula is patent and not clotted and to monitor for signs and symptoms of infection. LVN 4 further stated that routine pre and post dialysis assessments are necessary to promptly identify concerns, such as absence of bruit or thrill or signs of infection, and to ensure timely notification of the physician to prevent missed dialysis treatments. LVN 4 also stated the hemodialysis record serves as a communication tool between nursing staff and the dialysis provider, including documentation of the AVF status to ensure continuity of care. During a review of the facility policy and procedure (P&P) titled, “Dialysis Care,” last reviewed 4/16/2025, the P&P indicated that the “facility shall facilitate arrangements for ongoing dialysis care as ordered by the physician…IDT [An Interdisciplinary Team (IDT) in nursing is /a collaborative group of healthcare professionals—including nurses, physicians, social workers, and therapists—who work together to create and implement a comprehensive care plan for patients] shall assure that the resident`s/patient`s treatment plan includes resident`s/patient`s renal condition and necessary precautions i.e. shunt site, weights, dietary and fluid restrictions…observe for signs and symptoms of infection…”.	F0698		
F0732 SS = D	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F0732	F-732 Corrective Action for Affected Residents: This deficiency did not affect individual residents, as the issue pertains to the failure to post accurate and current nurse staffing information on 3/9/2026 and 3/10/2026. On 3/11/2026, the Director of Nursing (DON) or designee ensured that the nurse staffing information was posted with complete and accurate data, including the current date, resident census, and the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants for each shift (7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11	04/11/2026

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F0732 SS = D	Continued from page 58 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review the	F0732	Continued from page 58 p.m. to 7 a.m.). Identifying other Residents having the Potential to be Affected: This deficiency pertains to the posting of nurse staffing information and does not directly impact individual resident care. On 3/11/2026, the DON or designee verified that the nurse staffing information posting near the lobby nursing station is current, accurate, complete, and readily accessible to residents, staff, and visitors. Measures put into place or Systemic Changes: On 3/27/2026, the DON, Administrator and Chief Compliance officer reviewed the process for posting nurse staffing information to ensure compliance with regulatory requirements. The night shift RN Supervisor is now responsible for completing and posting the nurse staffing information at the beginning of the day shift (7 a.m.), which includes the facility name, current date, resident census, and the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants for each shift. On 3/29/2026, the Director of Education in-serviced the night shift RN Supervisors on the facility's policy and procedure titled "Administrative Manual," emphasizing the requirement to post complete and accurate nurse staffing information daily at the beginning of each shift in a clear and readable format in a prominent place readily accessible to residents, staff, and visitors. The DON and/or Director of Education in-serviced day shift and evening shift RN Unit Managers and RN Supervisors on the importance of verifying that the nurse staffing information is current and accurately reflects the actual hours worked by nursing staff, including any call-outs or absences. The Executive Administrative Assistant (EAA) or designee will serve as a backup to ensure the nurse staffing information is posted if the night shift RN Supervisor fails to complete the posting prior to 7 a.m. An audit tool was created to ensure nurse staffing information is posted. Completed on 4/2/26 Plan to Monitor Performance: Beginning 3/30/26, the DON or designee will conduct audits at the start of the day shift (7 a.m.) to verify that the nurse staffing information posted near the lobby nursing station includes the facility name, current date, resident census, and the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants for each shift. The audit tool will document compliance or non-compliance. If non-compliance is identified, the DON or designee will provide immediate feedback to the responsible RN Supervisor and supervisory intervention will occur as	

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F0732 SS = D	Continued from page 59 facility failed to ensure that staffing information, including the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift, was posted daily for two of two days (3/9/2026 and 3/10/2026), in accordance with the facility's policy and procedure (P&P) on "Administrative Manual." This deficient practice resulted in the total number of staff and the actual hours worked by the staff in the facility were not readily accessible to residents, staff and visitors. Findings: During an observation on 3/10/2026 at 2:30 p.m., a nurse staffing information posted near the lobby nursing station was dated 3/9/2026, and did not indicate the resident census, the total number and the actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistant s from 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m. During a concurrent observation and an interview with Registered Nurse 2 (RN 2) on 3/10/2026 at 2:33 p.m., observed nurse staffing information posted near the lobby nursing station. RN 2 stated that the nurse staffing information posting was dated 3/9/2026. RN 2 stated the staffing information was missing the actual resident census and the actual total hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants from 7 a.m. to 3 p.m., 3 p.m. to 11 p.m., and 11 p.m. to 7 a.m. RN 2 stated that the nursing staffing information should be posted daily and updated every shift so residents, family members, and staff can see the number of hours available for resident care. During an interview /and record review /on /3/10/2026 /at /3:35 /p.m., /with the Executive Administrative Assistant /(EEA), "JEKMC Nursing Census" /dated 3/9/2026 /and timed /3:47 p.m.; signed /on 3/10/2026 at 3:47 p.m. /was /reviewed. The EEA /stated /that the facility's nursing staffing information should be posted and updated daily at the beginning of each shift to inform the public the total number and actual hours worked by Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistant every shift. The EAA stated that the nursing	F0732	Continued from page 59 necessary. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0732 SS = D	Continued from page 60 staffing information for 3/10/2026 should have been posted by the night shift charge nurse to ensure the staffing information was visible to all staff, residents and visitors prior to the to the start of the morning shift (7 a.m.-3 p.m.). During an interview /and record review /on /3/11/2026 /at /8:33 /a.m., /with /Director of Nursing (DON), /the facility's policy and procedure (P&P) titled, /"Administrative /Manual" /was reviewed. /The /DON stated that the nurse staffing data /should be posted daily /at the beginning of each shift, including resident census and the /total number /and actual hours worked by the licensed and unlicensed nursing staff directly responsible for resident care per shift. The DON /stated /that facility policy was not followed, resulting in residents, staff and visitors being unable to /determine /how many staff worked on 3/9/2026 or who was scheduled to work on 3/10/2026. During a /review of facility's (P&P) titled, "Administrative Manual," revised on /4/16/2025, /the P&P indicated /the facility will /post the nurse staffing data /daily /at the /beginning /of each /shift. /Data will be posted clear and red /able format and in a prominent place readily accessible to /residents /and visitors the posting will include the /total number /and actual hours /worked /by the following categories of licensed and licensed /nursing staff directly responsible for resident care per shift /Registered /nurse, License practical /nurse, certified /nurse /assistant /and /resident /census.	F0732		
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F0755	F-755 Corrective Action for Affected Residents: On 3/17/2026, Resident 216's physician order for lactobacillus acidophilus 100 mg capsule was reviewed with provider and provider clarified the order to change it to the house supplied tablet formulation. Resident 216's medication administration was immediately corrected to ensure the tablet form is administered as prescribed. The RN Unit Manager verified on 3/17/2026 that Resident 216 received the correct tablet form of lactobacillus acidophilus 100 mg as ordered by the physician. Identifying other Residents having the Potential to be Affected: On 3/20/2026, the Director of Pharmacy conducted a comprehensive review of the Medication Administration Records (MARs) for the current residents to identify other medications with multiple	04/11/2026

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F0755 SS = D	Continued from page 61 the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of four residents received the correct form of medication in accordance with the physician's order when one of four sampled residents (Resident 216), who had an order for lactobacillus acidophilus (probiotic/supplement medication) in capsule form was administered the tablet form during the medication pass observation. This deficient practice had the potential to alter the medication absorption and effectiveness, resulting in suboptimal treatment or increased risk of adverse effects (unwanted or harmful reaction to a medication or treatment). Findings: During a review of Resident 216's Face Sheet (FS), the Face Sheet indicated the facility Resident 216 was originally admitted on 3/19/2022 and was re-admitted on 2/17/2026 with diagnoses including acute respiratory disease (condition in which your blood does not get enough oxygen or has too much carbon dioxide), chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure) and chronic obstructive pulmonary disease (COPD-group of lung diseases that block airflow and make it difficult to breathe).	F0755	Continued from page 61 formulations to ensure the residents' medication orders are consistent with the formulations. The Director of Pharmacy provided the list of resident's with these discrepancies and the RN Unit Managers verified and reconciled physician orders with the actual medication formulations available in the facility's medication supply. Any discrepancies identified were immediately corrected by obtaining the correct medication form as ordered and administering medications in accordance with physician orders. This was completed by 3/24/26. Measures put into place or Systemic Changes: DON and/or Director of Education in-serviced Licensed Nurses on the importance of administering medications in the exact form (capsule, tablet, liquid, etc.) as prescribed by the physician, emphasizing that substituting one form for another without a physician order modification can alter medication absorption and effectiveness. The DON or designee implemented a procedure effective 3/14/2026 requiring nursing staff to verify that the medication form (capsule, tablet, liquid, etc.) matches the physician order before administration, and to contact the pharmacist or pharmacy staff and the physician if the correct form is not available rather than substituting an alternative form. The in-service was completed on 4/2/2026. Plan to Monitor Performance: Beginning 4/6/2026, the facility pharmacist will conduct random audits of medication administration for a sample of residents (25 residents) weekly for four consecutive weeks to verify that medications ordered match the formulations being administered. After the four consecutive weeks, the pharmacist will conduct a monthly audit for 25 residents for three consecutive months. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee which meets at least quarterly will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYCE EISENBERG KEEFER MEDICAL CENTER D/P SNF	7150 TAMPA AVENUE , RESEDA, California, 91335

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F0755 SS = D	Continued from page 62 During review of Resident 216's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 12/19/2025, the MDS indicated Resident 216 has intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required mostly maximal (helper does more than half the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 216's Physician Order Report, the Physician Order Report, indicated an order dated 7/29/2024 for lactobacillus acidophilus (probiotic/supplement medication) 100 milligrams (mg-unit of measurement) one capsule orally once a day. During a concurrent observation, interview and record review with Licensed Vocational Nurse 1 (LVN 1) on 3/10/2026 at 8:43 a.m. Resident 216' s Medication Administration Record (MAR) was reviewed. Resident 216's MAR indicated to administer lactobacillus acidophilus 100 mg one capsule orally. During the medication pass observation, observed LVN 1 remove one tablet from the lactobacillus tablet medication container and administer the medication orally to Resident 216. LVN 1 stated that the facility only carried house supply of lactobacillus in tablet form and did not have the capsule form available. During an interview on 3/12/2026 at 9:20 a.m. with the Director of Nursing (DON), the DON stated that he was not aware that the facility does not carry house supply of lactobacillus in capsule form. The DON also stated that it is important to administer medication in accordance with the physician's order to ensure proper absorption and patient safety. During a review of facility's policy and procedure (P&P), titled, "Medication Administration," reviewed on 4/2025, the P&P indicated, "Medications will be administered in a timely manner and as prescribed by the resident's attending physician."	F0755		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	F-761 Corrective Action for Affected Residents: On 3/11/2026, Resident 72's discontinued Cipro (Ciprofloxacin HCL)	04/11/2026

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F0761 SS = D	Continued from page 63 §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to: 1. Remove Resident 72's discontinued medication from the medication cart after the physician discontinued the order in one (1) of five (5) inspected medication carts (Medication Cart 2). 2. Label an /over the counter /(OTC-medications available to consumers without a prescription) /medication in one of three sampled medication storage rooms (Medication Storage Room C) These deficient practices had the potential to result in a medication error by allowing discontinued medication to remain in the cart and creating the risk of administering medication to the wrong resident, lost medication, or delayed treatment. Findings:	F0761	Continued from page 63 500 milligrams was immediately removed from the medications cart 2 and discarded per policy by the RN Unit Manager. On 3/12/2026, the box of lozenges in Medication Storage Room C was immediately labeled with the resident's name and room number by the RN Unit Manager to ensure accurate identification and prevent administration to the wrong resident. Identifying other Residents having the Potential to be Affected: On 3/12/2026, the RN Unit Managers conducted an audit of Medication Carts 1, 3, 4, and 5 to identify the presence of discontinued medications in all medications carts and none was found. On 3/12/2026, the RN Unit Managers conducted an audit of Medication Rooms to identify over-the-counter medications and resident-owned medications lacking proper labels with resident name and room number. No additional unlabeled over the counter medications were found. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced Licensed Nurses on the facility policy and procedure titled "Disposition of Controlled and Non-Controlled Medication" revised 4/16/2025, emphasizing that discontinued non-controlled medications must be immediately removed from medication carts and placed in secured medication rooms in designated containers for disposition. In addition, education included the facility policy and procedure emphasizing that resident-owned over-the-counter medications must be labeled with the resident's name and room number to ensure accurate identification and prevent administration to the wrong resident. Completed 4/2/26. Plan to Monitor Performance: Beginning 4/6/26, the RN Unit Manager or Designee will conduct an audits of medication carts weekly to ensure discontinued medications are not stored in medication carts. Beginning 4/6/26, the RN Unit Managers or Designee will conduct random audits of medication storage rooms to ensure over-the-counter medications and resident-owned medications are properly labeled with the resident's name and room number. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0761 SS = D	Continued from page 64 1. During /a /review of Resident /72's /Face Sheet, the /Face Sheet /indicated the facility originally admitted Resident 72 on 12/06/2025 and was re-admitted on 2/17/2026 with diagnoses including sepsis a serious infection that is already affecting their organs, chronic kidney disease (CKD-a longstanding disease of the kidneys leading to kidney failure) and hypertension (high blood pressure). During a record review of Resident 72's History and Physical (H & P) dated 12/09/2025, the H&P /indicated /Resident 72 able to make simple medical decisions. During a review of Resident /72's Minimum Data Set /(MDS – a resident assessment tool), dated /2/13/2026, /the MDS indicated the resident 72 cognition /(relating to or involving the processes of thinking and reasoning) /was severely impaired. During a review of Resident /72's Physician Order Report (POR), dated 2/1/2026 to 3/31/2026, the Physician Order Report indicated that the physician's order dated 1/26/2026, for Cipro (Ciprofloxacin HCL) (a medication classified as an antibiotic used to treat infections) 500 milligrams(mg-unit of measurement) for urinary tract infection (UTI-infection caused bacteria entering the urinary system, commonly affecting the bladder) twice a day by mouth was discontinued on 3/10/2026. During an observation on 3/11/2026 at 10:12 a.m., with Licensed Vocational Nurse (LVN) 7, of the Controlled Medications ([CM] - medications which have a potential for abuse and may also lead to physical or psychological dependence, also known as Controlled Drugs or Controlled Substances {CS}) drawer of Medication Cart 2 there were two medication bubble packs (medication cards that contain individual doses sealed in clear plastic "bubbles" with a foil backing), each with 5 doses of Cipro 500 mg. During a concurrent interview and record of Physician Order Record on 3/11/2026 at 10:10 a.m. with LVN 7, LVN 7 stated there was an order for Cipro to be discontinued on 3/10/2026. LVN 7 stated that when a non-controlled medication order is discontinued, the standard practice is for nursing staff to place the discontinued medication in the medication room in the	F0761		

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F0761 SS = D	Continued from page 65 designated container, and if not used at all to return to the pharmacy. LVN 7 stated it is important to follow the facility policy of removing discontinued medications from the CM drawer to prevent medication error. LVN 7 stated the CM drawer was designed the storage of controlled medications, however, discontinued medications were also in the drawer. During a concurrent interview and review record of the Physician Order Report on 3/12/2026 at 10:23 a.m. with the Director of Nursing (DON), the DON stated based on their facility policy, when a non-controlled medication is discontinued the medication should be removed from the medication cart and placed in a secured medication room in the designated containers for disposition (facility's process for properly handling, removing, storing, returning, or destroying medications that are discontinued, expired, unused, or no longer required for the resident). The DON stated discounted medications should not be placed in the CM drawer to prevent medication error. 2. During a concurrent observation and interview /on /3/11/2026 at 10:48 am with Registered Nurse Supervisor (RN) 2 in Medication Storage Room C, a 36-count box of lozenges (medicated tablet designed to dissolve slowly in the mouth, providing temporary relief for sore throats, minor mouth irritations, and cough suppression) was stored without a /label indicating a resident's name or /expiration /date. RN 2 stated the medication box did not have an expiration date or the resident's name indicated. During an interview /on 3/11/2026 at 1:45 pm with the Pharmacist (Pharm), the Pharm /stated /the box of lozenges was not provided by the pharmacy and was an over-the-counter box of lozenge provided by a resident's family and the manufacturer did not provide an expiration date for the lozenges. During an interview on 3/11/2026 at 1:50 pm with RN 2, RN 2 stated over-the-counter lozenges should have had the resident's name written on the box because without a name, licensed nurses would not know who the lozenges belonged to. During an interview on 3/12/2026 at 2:00 pm with the Director of Nursing (DON), /the DON /stated /all medications in the medication storage rooms should be	F0761		

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F0761 SS = D	Continued from page 66 labeled. The DON /further stated /it is important to /label resident's own medications and over the counter medications with the resident's name and room number to ensure accurate identification, prevent administration to the wrong resident, and avoid causing distress to the resident. During a /review of facility's policy and procedure (P&P) titled, "Disposition of Controlled and Non-Controlled Medication," revised on /4/16/2025, the P&P indicated /when a non-controlled medication is discontinued or expired the medication shall be removed from the medication cart and placed in a secured medication room in the designated containers for disposition. The licensed nurse shall complete the Medication Disposition log. During a review of the facility's (P&P) titled, "Medication Labeling," revised 08/ 2019, the P&P indicated, resident's own over-the-counter medications should be labeled with /resident's /name and room number.	F0761		
F0804 SS = D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved appearance and flavor for lunch when chicken was served with some of the quills (the hollow central part of a feather) still in the skin for one of three residents (Resident 172) during dining observation. This failure had the potential to result in the resident not consuming meals or having poor food intake, which could lead to unintended weight loss.	F0804	F-804 Corrective Action for Affected Residents: On 3/9/2026, Resident 172 removed the skin from the chicken and proceeded to eat it in spite of an offer for a substitute. The Food Services Manager or designee has met with Resident 172 numerous times to discuss her concerns regarding chicken preparation and to ensure her satisfaction with meal presentation. They will continue to inspect her meals when chicken is on the menu for a few weeks. Identifying other Residents having the Potential to be Affected: On 3/19/2026, the Registered Dietitian (RD) and Food Service Supervisor designee reviewed the menu for all residents who were served chicken on the bone with skin during lunch service. On 3/30/26, the Food Services Manager and the Chef held a resident food committee meeting and asked if any other residents had concerns regarding the chicken. No other resident identified concerns. The Manager shared a change in vendors and dietary staff has been educated to check chicken prior to preparing it. The facility completed a comprehensive review of the current Kosher chicken supplier by 3/27/26 to evaluate the quality and consistency of the product. Measures put into place or Systemic Changes: On 3/9/2026, the Dietary Supervisor or designee implemented an immediate inspection protocol requiring	04/11/2026

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F0804 SS = D	Continued from page 67 Findings: During a review of Resident /172's /Face Sheet, /the /Face Sheet indicated the facility admitted Resident /87 /on /1/7/2026 /with diagnoses including /type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and gastro-esophageal reflux disease (a chronic condition where stomach acid frequently flows back up into the esophagus [food pipe]). During a review of Resident 172's History and Physical (H&P) dated 3/2/2026, the H&P indicated Resident 172 speaks in full sentences, was able to make her own needs known and able to make her own medical decisions. During a review of Resident /172's Minimum Data Set (MDS – an assessment and care screening tool) dated /2/13/2026, /the MDS indicated the Resident 172 makes himself understood and understood others. The MDS further /indicated /Resident /172 /needed supervision (helper provides verbal cues and/or touching assistance) for eating and oral hygiene and substantial assistance (helper does more than half the effort) with toileting, upper body dressing, lower body dressing, putting on/taking off shoes and personal hygiene. During an initial pool interview /on 3/9/2026 at /9:39 /a.m. with Resident 172 in her room, Resident 172 was sitting up in her wheelchair eating a snack. Resident 172 stated she was a caterer in the past and food along with its presentation is important to her. Resident 172 stated she loves chicken on the bone, and the skin is her favorite part and the chicken the facility uses gets served with quills in the skin and she cannot eat it. Resident 172 stated the facility follows Kosher food laws (a set of Jewish [religion, culture and shared ancestry] dietary regulations to determine which foods are ok to eat) and although they state that they burn them off, there are still lots of quill tips in the skin. During a concurrent observation and interview on 3/9/2026 at 12:11 p.m. in the fifth-floor bistro, Resident 172 was eating her lunch and asked the surveyor to come over. Resident 172 was eating the leg and thigh quarter of a chicken and stated there were quills in the skin. Resident 172 then pulled out several small quills, stated she was disgusted and	F0804	Continued from page 67 kitchen staff to inspect each piece of chicken on the bone with skin for quills after the torching process and prior to plating. On 3/19/26, the Director of Food Services identified an alternative Kosher chicken supplier that provides cleaner poultry with fewer quills or pre-processed to remove quills. On 3/19/26, the RD and Food Services Manager in-serviced kitchen staff, including cooks and food preparation staff, on the importance of food attractiveness and palatability, proper inspection techniques for chicken preparation, and the enhanced protocol for removing quills from chicken skin prior to plating. Director of Food Services confirmed new cleaner chicken has been ordered and is being served to residents. Plan to Monitor Performance: The Director of Food Services or designee will conduct daily audits of chicken preparation for a minimum of ten instances when chicken on the bone with skin is served to ensure kitchen staff are following the inspection protocol and chicken is free of quills prior to plating. The audit will include visual inspection of plated chicken and interviews with a sample of residents who received chicken to assess palatability and satisfaction. After three consecutive weeks of 100% compliance, the Director of Food Services or designee will decrease monitoring to three times per week for a minimum of ten instances each audit day for three consecutive weeks. After achieving 100% compliance for three consecutive weeks at the three times per week frequency, the Director of Food Services or designee will decrease monitoring to weekly audits for a minimum of ten instances for three consecutive weeks. After achieving 100% compliance for three consecutive weeks at the weekly frequency, the Director of Food Services or designee will conduct a final audit one month later. If 100% compliance is achieved, the facility will implement monthly audits as part of the ongoing Quality Assurance and Performance Improvement (QAPI) process. The Director of Food Services or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0804 SS = D	Continued from page 68 removed all of the skin and set it aside. During a concurrent observation and interview on 3/9/2026 at 12:16 p.m. in the fifth-floor bistro with Certified Nursing Assistant (CNA 2), CNA 2 looked at Resident 172's chicken skin and stated she has seen quills in the chicken skin before and the kitchen is aware. CNA 2 stated Resident 172 enjoys her food less and does not finish her meal when there are quills left in her chicken. During an interview on 3/9/2026 at 1:02 p.m. with the Dietary Supervisor (DS), the DS stated the chicken source must be Kosher and often times the chicken on the bone with skin usually have some quills and the kitchen staff uses a torch to burn the quills. The DS stated he was made aware of the quills and is looking for a new source that is Kosher to purchase from so the chicken can be appetizing for all the residents. During a review of the facility's Policy and Procedure (P&P) titled "Food Presentation," last reviewed 4/16/2025, the P&P indicated meals served to residents shall be presented in an attractive, appetizing and sanitary manner that promote adequate nutrition and resident satisfaction. During a review of the facility's P&P titled "Meal Delivery Service," last reviewed 4/16/2025, the P&P indicated the meals shall be delivered to the residents in an attractive manner...and will meet the diets, consistency and personal preferences. During a review of the facility's P&P titled "Standardized Recipes," last reviewed 4/16/2025, the P&P indicated the facility cooks shall follow recipes including the proper cutting, slicing and other preparations of ingredients.	F0804		
F0805 SS = D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet	F0805	F-805 Corrective Action for Affected Residents: On 3/27/2026, the Registered Dietician (RD) reviewed Resident 3's dietary order for a fortified, soft and bite-sized diet. RD updated the spreadsheet to indicate bread items will be pureed for this diet type at this time. RD observed three meals (3/27/26, 3/30/26, 3/31/26) to verify that Resident 3's meals were prepared to meet the soft and bite-sized diet texture requirements.	04/11/2026

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F0805 SS = D	Continued from page 69 individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs for one out of ten residents (Resident 3) observed while dining when Resident 3 was served a sandwich made with softened bread with the crusts left on while on a soft and bite-sized diet (foods that are soft, tender, moist, and easy to chew and swallow). This deficient practice had the potential to result in Resident 3 having difficulty with chewing and swallowing leading to a potential decrease in food intake and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of Resident 3's Face Sheet, the Face Sheet indicated the admitted the resident on 2/8/2024 with diagnoses including, but not limited to, chronic (long-term) atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's Minimum Data Set (MDS – a resident assessment tool), dated 1/1/2026, the MDS indicated the resident had severe cognitive impairment (trouble with thinking, learning, and remembering clearly). The MDS indicated Resident 3 was dependent (helper does all of the effort) on staff for toileting, bathing, and personal hygiene. The MDS indicated Resident 3 required substantial assistance (helper does more than half of the effort) with eating, oral hygiene, and dressing. During a review of Resident 3's Physician Order Report, the Physician Order Report indicated an order for a fortified (adding additional nutrients), soft and bite-sized diet, dated 6/4/2025. During a review of the facility's Menu and Diet Guidelines Manual titled, "Summary of Diets," last reviewed April 2025, the manual indicated a soft and bite-sized diet follows the guidelines for	F0805	Continued from page 69 Identifying other Residents having the Potential to be Affected: The RD conducted a review of the current resident census to identify residents with orders for soft and bite-sized diets or IDDSI Level 6 texture modifications, 32 additional residents have orders for this diet. The RD reviewed meal preparation with the Food Service Director and bread items will be pureed to meet the needs of residents with "soft and bite size" diets at this time. RD modified spread sheet to reflect change and observed meals served to residents with "soft and bite sized" diets to verify meals were prepared to meet the diet texture requirements. Any discrepancies identified were immediately corrected and communicated to the Food Service Director. Measures put into place or Systemic Changes: On 3/19/2026, the RD and Food Services Manager provided an in-service for dietary staff (including cooks, dietary aides, and food service workers) on proper food preparation for soft and bite-sized diets according to IDDSI Level 6 standards. The RD and Director of Food Services met on 3/31/26 and will change bread items to pureed at this time to ensure safety for the residents. The RD revised the Menu spreadsheets to reflect bread items to be pureed for residents on "soft and bite size" diets. Completion date 4/11/26 Plan to Monitor Performance: Beginning 4/6/2026, the RD or designee will conduct daily audits of meal trays for residents on soft and bite-sized diets for five consecutive days to ensure bread products are prepared according to guidelines (pureed). If 100% compliance is achieved for five consecutive days, the RD or designee will decrease monitoring to three times per week for two consecutive weeks. If 100% compliance is maintained, the RD or designee will decrease monitoring to weekly. If any deficiency is identified during monitoring, the RD or designee will provide immediate re-education to dietary staff and restart the monitoring schedule at daily frequency. The RD or Food Service Director will provide data during the Quality Assurance and Performance Improvement Committee meeting which meets at least quarterly. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved and will make additional recommendations as needed to improve this service.	

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F0805 SS = D	Continued from page 70 International Dysphagia Diet Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) level 6 with a texture modification of soft foods that are easy to chew and swallow. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive), titled "Spread Sheet Week 8 Winter 2026," dated 3/10/2026, the spreadsheet indicated residents on a soft and bite-sized diet would include a krab (imitation crab meat) salad roll and a soaked soft bun. During a concurrent observation and interview on 3/10/2026 at 12:19 p.m. with Certified Nursing Assistant (CNA) 3 and Resident 3, CNA 3 assisted Resident 3 to eat lunch. Observed the krab salad roll was served in bread which had the crusts on. CNA 3 stated the crust was still on the bread, but the bread was moistened so the resident can chew it more easily since she is on a soft and bite-sized diet. During an interview on 3/12/2026 at 10:34 a.m. with the Registered Dietician (RD), the RD stated the sandwich bread for a soft and bite-sized diet should be prepared following the IDDSI standards. The RD stated per the IDDSI standards the crusts on the bread should be removed then the bread should be soaked with liquid. The RD stated the IDDSI standards should be followed so that they can provide a safe diet texture to the residents and minimize the risk of choking. During a review of the IDDSI guidelines provided by the facility titled "Level 6 Soft and Bite-Sized for Adults," dated January 2019, the guidelines indicated to avoid any crust which is formed during cooking or heating as it poses a choking risk.	F0805		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use	F0842	F-842 Corrective Action for Affected Residents: On 3/16/2026, Resident 94's Medication Administration Record (MAR) was reviewed by the RN Unit Manager and was unable to make any corrections since it was past the window of time for correction (two weeks). Resident 94 experienced no adverse effects from the inaccurate documentation, as confirmed through assessment by the RN Unit Manager. Identifying other Residents having the Potential to be	04/11/2026

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F0842 SS = D	Continued from page 71 or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there	F0842	Continued from page 71 Affected: On 3/25/2026, the Medical Records Manager identified residents currently receiving insulin injections. The RN Unit Managers conducted an audit of the MARs for these identified residents for the period of 3/01/2026 through 3/25/2026 to identify any inaccurate documentation of insulin units, blood glucose levels, or injection sites. Two out of 18 residents with orders for insulin injections were identified to have inaccuracies and they were corrected in the respective resident's MAR by 3/31/2026. The RN Unit Manager assessed each resident with inaccurate MAR documentation to ensure no adverse effects occurred. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced Licensed Nurses emphasizing accurate MAR documentation for insulin administration, proper documentation of injection sites, blood glucose levels, and insulin units administered. The in-service included case study examples of correct and incorrect documentation. LVN 4 was in attendance of the education session. Plan to Monitor Performance: RN Unit Manager and/or RN Supervisor will conduct random audits of MARs for residents receiving subcutaneous insulin injections, reviewing a minimum sample of 10% of residents receiving insulin or a minimum of five residents, whichever is greater. The audits will verify accurate documentation of insulin units administered, blood glucose levels, and injection sites, ensuring no fields contain "0" inappropriately. Audits will be conducted weekly. If any non-compliance is identified at any point, the RN will provide immediate re-education to the licensed nurse(s) involved. The DON or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0842 SS = D	Continued from page 72 is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to accurately document /the blood /glucose (BG-the main sugar found in the bloodstream) level, /amount of the insulin (medication that lowers the blood sugar) /units, and /injection site /in Medication /Administration /Record (MAR) for one of two sampled /residents /(Resident /94). This deficient practice had the potential to negatively impact on the delivery of treatment and services to Resident 94. Findings: During /a /review of Resident /94's /Face Sheet, the /Face Sheet /indicated the facility originally admitted Resident /94 /on 10/01/2023 /and re-admitted resident on 1/12/2025, with diagnoses including diabetes mellitus /(DM-a chronic condition that affects the way the body processes blood sugar [glucose]), /with diabetic polyneuropathy (nerve damage caused by diabetes that makes feet or hands feel numb, tingly, or painful), /mild cognitive impairment(mild thinking or memory problems) /of uncertain or unknow /etiology (illness), and /peripheral vascular disease(a condition	F0842		

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F0842 SS = D	Continued from page 73 where blood vessels outside heart and brain usually in legs become blocked or narrowed, causing poor blood flow). During a record review of Resident /94's History and Physical (H & P) dated /2/27/2026, the H&P /indicated /Resident /94 /does have the capacity to understand and make decisions on her own. During a review of Resident /94's MDS dated /1/02/2026, /the MDS indicated the resident /94's cognition /(relating to or involving the processes of thinking and reasoning) /is /intact. During a record review of Resident /94's /Physician Order Report dated 3/1/2026 to 3/10/2026, /the Physician Order indicated /an order dated 3/21/2025 for the following: -Novolog (fast acting insulin) /insulin /8 units; /subcutaneous (under /skin) /for /DM /; please rotate the site, hold Novolog if /blood sugar /less /than /100 /milligrams per deciliter((mg/di) /a unit of measurement /to indicate how many milligrams of as glucose /are present in one deciliter (100 /mL) of blood /) /, once /a day, at /7:30 /a.m. - /Novolog (fast acting insulin) /insulin /8 units; /subcutaneous (under /skin) /for /DM /; please rotate the site, hold Novolog if /blood sugar /less /than /100 /milligrams per deciliter((mg/di) /a unit of measurement /to indicate how many milligrams of as glucose /are present in one deciliter (100 /mL) of blood /), once /a day, at 11:30 a.m. During a record review of Resident 94's Medication Administration Record (MAR) /dated 3/01/2026 to 3/10/2026, the MAR /indicated /that for the order Novolog 8 units subcutaneously at 7:30 a.m., on 3/4/2026, 3/5/2026, 3/7/2026, and 3/9/2026., the injection site was documented as "0." During a record review of Resident 94's MAR dated 3/01/2026 to 3/10/2026, the MAR /indicated that the order for Novolog 8 units subcutaneously scheduled for 11:30 a.m., on 3/8/2026 at 11:30 a.m., the "Units" field /indicated /"115," and the BG result was documented as "0."	F0842		

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F0842 SS = D	Continued from page 74 During an /interview and record review on /3/10/2026 /at /1:8 /p.m., /with the DON, /Resident /94's /MAR dated 3/01/2026 to 3/10/2026 was reviewed. The DON /stated /licensed nurses should document the injection site in the MAR, such as "Left upper arm." If the medication is /not /administered, they (licensed nurses) should enter "N/A." The /DON /stated that licensed nurses should not document "0" in that field because it can create confusion. /The /DON /stated /that the purpose of documenting the injection site is to ensure proper rotation of sites as required by the physician's order. The BG level in the MAR /indicates /the resident's blood glucose reading, which is normally between 80 and 120 and documenting a BG of "0" is inaccurate, because a /true BG of 0 would mean no glucose in the bloodstream, which would /immediately /result in loss of consciousness and death. Therefore, the current documentation is not /accurate /and needs to be corrected. The DON further stated licensed nurses should document the number of insulin units they administer to the /residents /in the MAR. Based on the physician's Resident 94 should receive 8 units. The DON /stated /that staff incorrectly documented "115" units, which is not possible, because /if Resident /94 /received 115 units of insulin the resident would have experienced severe hypoglycemia and /likely go /into a hypoglycemic coma. The DON further stated that Resident /94 /is healthy, which confirms she did not receive 115 units. Therefore, the documentation is inaccurate and must be corrected. During a concurrent interview and record review on /3/12/2026 /at /8:30 /a.m., /with Licensed /Vocational /Nurse /(LVN) /4 /Resident /94's /MAR dated /3/01/2026 to 3/10/2026 /was reviewed. /LVN4 stated she was assigned to Resident 94 on 3/8/2026, and she is the one who documented "115 units" of insulin administered for a BG level of "0." /for the /11:30 a.m. medication pass. /LVN 4 /stated that she did not administer 115 units of insulin, and a BG level of 0 was not /accurate. She /stated /she made a mistake and incorrectly documented the /units of insulin and BG level in the MAR. LVN4 /stated /she documented the injection site as "0" for the dates 3/4/2026, 3/7/2026, and 3/9/2026 for the 7:30 a.m. medication pass, which is not correct because If the resident does not receive any insulin, the site should be documented as "N/A" /not "0". During a /review of facility's P&P titled, "Medication	F0842		

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F0842 SS = D	Continued from page 75 Administration," revised on /4/16/2025, /the P&P indicated /documentation of Medication /Administration, /the individual administering the /medication must initial the residents/ patients MAR on the /appropriate line /and date for the specific day before administering the next residents / /patient's /medication. Charting Medication Administration data: When medications are administered, the individual administering the medication must record in the residents/ /patient's /medical record: • The date and time the medication was administered • The dosage • The route of administration • The injection site (if applicable) • Any complaints or symptoms for which the drug was administered • Any results achieved and the time such results were observed • The signature and title of the person administering the drug.	F0842		
F0847 SS = D	Entering into Binding Arbitration Agreements CFR(s): 483.70(m)(1)(2)(i)(ii)(3)-(5) §483.70(m) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section. §483.70(m)(1) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to continue to receive care at, the facility.	F0847	F-847 Corrective Action for Affected Residents: On 3/27/2026, the Admissions Director (ADIR) contacted the responsible Family Member of Resident 34 (FM34) to verbally explain the terms of the agreement in a form and manner they understand, including: that arbitration is voluntary; that signing is not required for admission or continued care; that they have the right to consult an attorney; and that they have the right to rescind the agreement within 30 calendar days of signing. The ADIR documented the date and time of contact with each family member and confirmation of their understanding of the agreement. This was completed by 3/27/2026. On 3/27/2026, the ADIR sent a copy of the signed Arbitration Agreement to FM34 via email, clearly labeled as "Voluntary Arbitration Agreement". The ADIR explained the terms of the new agreement in a form and manner that FM34 understands and ensured FM34 acknowledged understanding of the agreement by her	04/11/2026

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F0847 SS = D	Continued from page 76 §483.70(m)(2) The facility must ensure that: (i) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands; (ii) The resident or his or her representative acknowledges that he or she understands the agreement; §483.70(m)(3) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing it. §483.70(m)(4) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility. §483.70(m)(5) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with §483.10(k). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure the binding arbitration agreement (arbitration agreement, a binding agreement by the parties to submit to arbitration all or certain disputes which have arisen or may arise between them in respect of a defined legal relationship. The decision is final, can be enforced by a court, and can only be appealed on very narrow grounds) was explained to residents' representatives in a form and manner that he or she understands for 1 (Resident 34) of 4 sampled residents. This had the potential for residents' rights to not be honored. Findings:	F0847	Continued from page 76 signing in the DocuSign. This was completed on 3/27/2026. Identifying other Residents having the Potential to be Affected: On 3/26/26, audit by Medical Records Manager identified 79 additional residents admitted to the facility from 1/1/2025 to 3/26/2026 who have signed Arbitration Agreements. The ADIR reviewed the admission records to determine whether the Arbitration Agreement was explained to the resident or their representative in a form and manner they understand. On 3/26/2026, the ADIR initiated contacting the representatives of the 79 residents identified in the audit to provide copies of the Arbitration Agreement and verbally explain the terms of the agreement in a form and manner they understand. The ADIR sent signed Arbitration Agreements to representatives via email, clearly labeled as "Voluntary Arbitration Agreement", and ensured each representative acknowledged understanding of the agreement by returning signed via DocuSign. This was completed by 4/11/2026. Measures put into place or Systemic Changes: On 3/13/2026, the Administrator (ADM) developed an "Arbitration Agreement Explanation and Acknowledgement form" (AAEA) to ensure it is a separate, stand-alone document clearly labeled, and is not embedded within admission paperwork. The newly developed agreement explicitly states that the resident or their representative is not required to sign the agreement as a condition of admission or to continue to receive care at the facility, explicitly grants the right to rescind the agreement within 30 calendar days of signing, and does not contain language that prohibits or discourages communication with federal, state, or local officials. On 3/16/2026, the ADIR revised the electronic admission packet process to ensure the Arbitration Agreement Explanation and Acknowledgement form (AAEA) is sent as a separate email transmission from admission documents, allowing residents' representatives to decline signing the Arbitration Agreement without affecting their ability to complete admission paperwork. An LAJH Facilities Arbitration Agreement Log" was created for Admissions to track that Arbitration Agreements were explicitly explained. On 3/13/2026 and 3/27/26, the Chief Compliance Officer in-serviced the Administrator (ADM) and ADIR on the newly developed Arbitration Agreement process,	

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F0847 SS = D	Continued from page 77 During a review of Resident 34's Face Sheet (the front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated the resident was admitted to the facility on 2/11/2026 with diagnoses that included age-related physical debility (frailty, a syndrome characterized by progressive loss of muscle mass and reduced strength). During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 2/19/2026, the MDS indicated Resident 34 was moderately impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 34 required setup or clean-up assistance (helper sets up or cleans us; resident completes activity) with eating. During a review of Resident 34's Arbitration Agreement, the document indicated Family Member of Resident 34 (FM34) signed the agreement on 2/06/2026. During a telephone interview with FM34 on 3/11/2026 at 10:18 a.m., she stated she was unaware of the document. FM10 stated she was not sure what an arbitration agreement was. FM10 stated she did not recall signing an arbitration agreement when she signed Resident 34's admission paperwork. During a concurrent record review and phone interview, the Admissions Director (ADIR) on 3/11/2026 at 1:31 p.m., the ADIR reviewed the facility's policy and procedure titled, "Arbitration," last reviewed 4/16/2025 which indicated: The arbitration agreement: Must be separate from the admission agreement. Must be clearly labeled as "Voluntary Arbitration Agreement." Must not be embedded within admission paperwork. Admissions staff shall verbally explain: Arbitration is voluntary. Signing is not required for admission or continued	F0847	Continued from page 77 including: Arbitration Agreement Explanation and Acknowledgement form (AAEA), and verbally explaining the Arbitration Agreement to every resident or their representative in a form and manner they understand, including in a language they understand; informing residents or their representatives that arbitration is voluntary and not required for admission or continued care; informing residents or their representatives of their right to consult an attorney; informing residents or their representatives of their right to rescind the agreement within 30 calendar days; ensuring the Arbitration Agreement is sent separately from admission documents; documenting verbal explanation and acknowledgment of understanding in the resident's record; and complying with the facility's policy titled "Arbitration" last reviewed 3/12/2026. On 3/27/2026, the ADIR in-serviced the Admissions Department staff on the revised Arbitration Agreement process, including: verbally explaining the Arbitration Agreement to every resident or their representative in a form and manner they understand, including in a language they understand; informing residents or their representatives that arbitration is voluntary and not required for admission or continued care; informing residents or their representatives of their right to consult an attorney; informing residents or their representatives of their right to rescind the agreement within 30 calendar days; ensuring the Arbitration Agreement is sent separately from admission documents; documenting verbal explanation and acknowledgment of understanding in the resident's record; and complying with the facility's policy titled "Arbitration" last reviewed 3/12/2026. Plan to Monitor Performance: Beginning 3/16/2026, the Admissions Director (ADIR) or designee will conduct audits of residents admitted to the facility on a monthly basis to ensure: the Arbitration Agreement is sent separately from admission documents; including the Arbitration Agreement Explanation and Acknowledgement form (AAEA) and the Arbitration Agreement was verbally explained to the resident or their representative in a form and manner they understand; the resident or their representative acknowledged understanding of the agreement; and documentation reflects the explanation and acknowledgment. The Administrator (ADM) or designee will report monitoring plan results monthly to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement	

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F0847 SS = D	Continued from page 78 care. Resident has the right to consult an attorney. Resident may rescind within 30 days (recommended best practice). The ADIR stated, since approximately 2/26/2026, the facility has been emailing the arbitration agreement with a letter indicating this was a voluntary document to sign, separate from the admission paperwork. The ADIR stated she does not verbally explain the arbitration agreement, as per facility policy, to residents' families unless they ask questions. The ADIR stated by signing the letter this means residents' families understand what the arbitration agreement document is. During a concurrent interview and record review with the Administrator (ADM) on 3/12/2026 at 2:43 p.m., the ADM reviewed the facility's policy and procedure titled, "Arbitration," last reviewed 4/16/2025. The ADM stated the facility recently has been emailing the arbitration agreement with a letter indicating this was a voluntary document to sign, separate from the admission paperwork. The ADM stated by signing the letter this means residents' families understand what the arbitration agreement document is. The ADM stated it is important for residents and residents' families to know what an arbitration agreement is, that they are signing an agreement and it is important for them to know what their signature means in a legal document and the implications of it including that it is voluntary, not a condition for admission, can rescind within 30 days, and can consult an attorney.	F0847	Continued from page 78 (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and	F0880	F-880 Corrective Action for Affected Residents: On 3/10/2026, the Infection Preventionist (IP) replaced the incorrect contact precautions sign on Resident 72's door with the correct contact and spore precautions sign, which instructs staff to wash hands with soap and water to remove C.diff spores. On 3/11/2026, the Director of Nursing (DON) or designee re-educated Licensed Vocational Nurse 3 (LVN 3) on the proper use of personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (EBP), including the requirement to remove isolation gowns and gloves before exiting a resident's room. Resident 40 was not impacted by LVN not removing PPE.	04/11/2026

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F0880 SS = E	Continued from page 79 control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880	Continued from page 79 Identifying other Residents having the Potential to be Affected: On 3/11/2026, the IP or designee conducted a facility-wide audit of all residents on transmission-based precautions (TBP) and EBP to verify that appropriate signage is posted on resident room doors matching the specific precaution type required. Other residents on isolation had the correct signage on their door. No other residents in the facility had C.diff requiring isolation precautions. On 4/1/26/2026, the IP conducted observations of licensed nursing staff during medication passes and care activities for residents on TBP and EBP to identify any additional instances of improper PPE use or failure to follow isolation precautions. If any licensed nurse was observed not following the procedure, education was provided on the spot. Measures put into place or Systemic Changes: The DON and/or Director of Education in-serviced licensed nursing staff on the facility's "Guideline for Isolation Precautions" policy, emphasizing the differences between contact precautions requiring alcohol-based hand rub (ABHR) and contact and spore precautions requiring handwashing with soap and water for C.diff infections. Education also included the facility's "Enhanced Barrier Precautions" policy, emphasizing that PPE (gowns and gloves) must be removed before exiting a resident's room to prevent cross-contamination with equipment, surfaces, and other residents. On 4/6/2026, the IP implemented a weekly review process of all residents on TBP and EBP to ensure appropriate signage is posted and updated as needed based on current infection status. Plan to Monitor Performance: The IP or designee will conduct random audits weekly of resident rooms with TBP and EBP to verify correct signage is posted and matches the resident's current infection control requirements. The IP or designee will conduct random observations of licensed nursing staff weekly during medication passes and care activities for residents on TBP and EBP to ensure proper donning and doffing of PPE and adherence to hand hygiene protocols. The IP or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0880 SS = E	Continued from page 80 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to implement the facility's infection control policy when: 1. An incorrect sign was placed on the door of one of one resident (Resident 72) on transmission-based precautions (TBP - extra infection control measures used in healthcare settings, beyond standard precautions, for patients known or suspected to be infected with highly infectious pathogens [virus, bacteria, fungus] investigated under the infection control task. This deficient practice had the potential to increase the risk of spreading infection to other residents. 2.. Licensed Vocational Nurse 3 (LVN 3) /was observed leaving a resident's room during a medication pass observation while still wearing an isolation gown for one (Resident /40) of /13 /residents who /were /on enhanced barrier precautions /(EBP-a method of using personal protective equipment [PPE – clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments] to reduce the spread of pathogens between residents in skilled nursing facilities). This deficient practice had the potential to increase the risk of spreading infection to other residents. Findings: 1. During a /review of Resident /72's Face Sheet, the Face Sheet /indicated the facility admitted the resident on /2/17/2026 /with diagnoses including unspecified /severe sepsis /(a life-threatening blood	F0880		

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F0880 SS = E	Continued from page 81 infection) /and Parkinson's disease /(a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident /72's /History and Physical (H&P) dated /12/10/2025, the H&P /indicated /Resident /72 /speaks in full sentences, was able to make her /own needs known and able to make /simple /medical decisions. During a /review of Resident /72's Minimum Data Set (MDS - an assessment and care screening tool) dated /2/13/2026, indicated Resident /72 /usually makes herself understood and usually understands others. The MDS further /indicated /Resident /72 required substantial assi stance /(helper does more than half the work) /with /upper body and lower /dressing, personal hygiene /and putting on and taking off shoes. During a review of the facility provided matrix (A /list of residents combined with a checklist that identifies who has specific care needs such as TBP) on 3/9/2026, Resident 72 was identified as being placed on TBP. During a review of Resident 72's Clostridioides difficile (C.diff, a bacterium that causes severe diarrhea and intestinal inflammation) test results dated 3/6/2026, the test results indicated Resident 72 was positive for C.diff toxins (harmful substance that C. diff produces) and requires contact isolation. During a concurrent observation and interview on /3/10/2026 /at /9:42 /a.m. outside of Resident /72's room /with the Infection Preventionist (IP), the IP looked at the contact precautions (infection spread by touching) sign on the door and stated it was in fact the wrong sign. The IP stated C. diff infections require handwashing to remove the C.diff spores (the dormant, inactive, and highly resistant form that can live for months) from the hands and the current contact precaution sign instructed to use alcohol-based hand rub (ABHR - a liquid, gel, or foam antiseptic [chemical substance meant to kill germs] designed to kill the majority of germs on hands without the need for soap and water) and that sign is not enough to prevent the spread of C. diff.	F0880		

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F0880 SS = E	Continued from page 82 During an interview on /3/13/2026 /at /2:28 /p.m., /with /the Director of Nursing (DON), the DON /stated /licensed staff are responsible for checking and observing infection control guidelines to keep residents safe. The DON stated that for C. diff infections, the sign must include to wash the hands with soap and water after assisting the resident to ensure all the spores are washed off. During a review of the facility's policy and procedure /(P&P) /titled, "Guideline for Isolation Precautions," last reviewed /4/16/2025, /the P&P /indicated there are three different kinds of transmission (mode in which the germs can infect) and contact is one of the three. The P&P stated contact transmission is when germs are transferred directly from person to person through touch. The P&P further indicated residents with C.diff will be placed on contact and spore precaution indicating the need for handwashing with soap and water. 2. During a review of Resident /40's Face Sheet, the Face Sheet indicated the resident was admitted to the facility on /3/16/2021 /and re-admitted on 1/03/2026 /with diagnoses that included /dysphagia (difficulty swallowing), /attention to gastrostomy /(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident /40' s MDS, dated /1/01/2026, the MDS indicated Resident /40 /was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident /40 /was dependent (helper does all the effort) on staff for eating. /The MDS indicated Resident 40 has a gastrostomy tube /(G-tube, /a plastic tube inserted into the stomach to infuse medications for one who has problems swallowing). During a review of Resident /40's Physician's Orders, /dated 12/18/2024, /the physician's orders /indicated /EPB are to /be /maintained /during high-contact resident /care activities due to G-tube feeding. During a medication pass observation with /LVN	F0880		

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F0880 SS = E	Continued from page 83 3 /on /3/11/2026 /at /3:58 /p.m., observed /LVN 3 /taking /Resident 40's /blood pressure in /isolation /gown and gloves. /LVN 3 /then /removed /their gloves and /walked /towards the medication cart which was placed right outside /Resident /40's room /at the /doorway. /LVN 3 was /still wearing an /isolation /gown. When /asked if his isolation gown could /potentially /come in contact with /the medication cart, he /stated /he was not aware /this could be an infection control issue. During an interview with the DON on /3/12/2026 at 8:15 a.m., /the DON /stated /staff providing care for /residents who are on EBP, the practice is to remove the isolation gown /and gloves /before leaving a resident's room. /The DON stated /LVN 3 /should have removed the gown /before /exiting /Resident /40's room. The DON /stated /this was important to /prevent the spread of infection. During a review of the facility's policy and procedure titled, "Enhanced Barrier Precautions, /last reviewed /4/16/2025, /the policy indicated EBP is used in conjunction with /standard precautions /(a set of infection control practices that are used to prevent the spread of disease in healthcare settings, such as hand washing) /and expand the use of PPE during high-contact resident care activities. /The policy indicated EBP /are /to be used for /residents with /indwelling /medical devices, such as a G-Tube, even if the resident is not known to be infected or colonized with a /multidrug-resistant /organism (MDRO, /bacteria that are resistant to three or more classes of antimicrobial drugs). /The policy /indicated /the PPE: gloves and gown, are to be /used in maintaining EBP.	F0880		
F0908 SS = D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure patient care equipment was maintained in safe, comfortable operating condition for one of five sampled residents (Resident 78) by failing to ensure Resident 78's wheelchair was repaired in a timely manner when Resident 78's wheelchair push rim (also called hand rim-metal or plastic ring attached to	F0908	F-908 Corrective Action for Affected Residents: On 3/11/2026, the Central Supply Supervisor (CSS) or designee replaced Resident 78's wheelchair push rim protectors with new protectors, removing the black plastic tape. The Director of Rehabilitation (DOR) or designee evaluated Resident 78 on 3/12/2026 to ensure Resident 78 was able to comfortably and effectively propel the wheelchair without discomfort or pain. Identifying other Residents having the Potential to be Affected: On 3/12/2026, the DOR or designee conducted an audit of residents utilizing wheelchairs to identify residents with damaged, taped, or improperly functioning wheelchair components including push rims,	04/11/2026

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F0908 SS = D	Continued from page 84 the outside of a manual wheelchair's large wheels that allow users to self-propel [push/move]) was damaged. This deficient practice resulted in Resident 78's inability to comfortably propel her wheelchair and had the potential to negatively affect the provision of care and service provided to Resident 78. Findings: During a review of Resident 78's Face Sheet (FS), the FS indicated the facility originally admitted Resident 78 on 2/1/2025 and re-admitted on 2/9/2025 with diagnoses including cellulitis (bacterial skin infection) of right upper limb (arms/legs), right elbow bursitis (painful inflammation or swelling of a bursa [small, fluid-filled sac that cushions bones, and muscles]) and abnormalities of gait (manner, style or pattern of walking) and mobility (ability to move, walk, or change in positions easily, freely, and independently). During review of Resident 78's Minimum Data Set (MDS - a comprehensive standardized assessment and care-screening tool), dated 2/17/2026, the MDS indicated Resident 78 has intact (undamaged/complete) cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and required supervision (helper provides verbal cues, touching and/or contact guard assistance as resident completes activity) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS also indicated that Resident 78 has been using a wheelchair as a mobility device. During a concurrent observation and interview on 3/9/2026 at 10:21 a.m., with Resident 78 inside Resident 78's room, observed Resident 78's wheelchair push rims covered with black plastic tape around the entire rims. Resident 78 stated it is uncomfortable to use the wheelchair as she was unable to effectively propel herself due to pain when touching the push rims covered with plastic tape. Resident 78 further stated that a facility staff had notified her (Resident 78) they (facility) were awaiting insurance approval for replacement push rim covers. During a concurrent interview and record review on	F0908	Continued from page 84 protectors, and other essential wheelchair parts. One resident was identified with a wheelchair equipment issue and was referred to the CSS for immediate repair and was completed on the same day 3/24/26. Measures put into place or Systemic Changes: The Director of Purchasing educated the CSS on the importance of timely repair and replacement of patient care equipment, including wheelchairs and mobility devices, to ensure resident comfort, safety, and the provision of individualized care. The in-service included review of the facility's policy and procedure titled "Medical Equipment" and "Accommodation of Needs," emphasizing that equipment repairs must be completed within 24 hours when parts are in stock, and that temporary fixes such as taping must not compromise resident comfort or ability to safely use equipment. Plan to Monitor Performance: The Director of Purchasing or designee will conduct random audits of a minimum sample of 10% of residents utilizing wheelchairs and other patient care equipment weekly for four consecutive weeks, then monthly for three months, to ensure equipment is maintained in safe, comfortable operating condition and repairs are completed within established timeframes. The DOP or designee will review the CSS repair log monthly to ensure timely completion of repairs. The DOP or designee will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved.	

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F0908 SS = D	Continued from page 85 3/11/2026 at 10:43 a.m., with the Director of Rehabilitation (DOR), Resident 78's Physical Therapy Evaluation and Plan of Treatment (PTEPT) dated 2/20/2026 and Discontinued General Order (DCGO), dated 2/20/2026 were reviewed. Resident 78's PTEPT indicated Resident 78 was evaluated for wheelchair maneuvering (moving) and Resident 78's requested for wheelchair push rim protectors due to damage. The PTEPT also indicated that central supply will provide and install new wheelchair push rim protectors. The DCGO indicated a physician order for central supply to provide resident with two wheelchair rim protectors and to install them. The DOR stated that the Central Supply Supervisor (CSS) had fixed Resident 78's wheelchair push rim by reinforcing the previous unlatched protector with a black plastic tape around and not installing a new protector. The DOR stated that the DOR was again made aware on the previous week that Resident 78 was not happy since it causes discomfort due to Resident 78's possible sensitivity to the tape. The DOR stated that she had notified the Director of Nursing (DON) regarding the issue and the DON had emailed the CSS to replace the whole wheelchair rim protector on 3/6/2026. During a concurrent interview and record review on 3/11/2026 at 12:21 p.m. with the CSS, a facility's document, titled, "Request Forms" was reviewed. The form indicated that on 2/20/2026, there was a request for two wheelchair push rim protectors to be installed for Resident 78. The form also indicated that the CSS had only added plastic tape around it. The CSS verified and stated that on 2/20/2026, he placed black plastic tape around the wheelchair rim protector due to the original rim was no longer latching properly. The CSS stated that a second request to fully replace the push rim protector was made on 3/6/2026 via the DON's email. The CSS stated that requests are expected to be fulfilled within 24 hours if the item is in stock and confirmed that the rim protectors were available and did not require ordering. The CSS stated that he was only able to complete the replacement today, 3/11/2026 and acknowledged that it was important to replace the wheelchair push rim protectors promptly, as the condition of the wheelchair was causing discomfort to Resident 78. During an interview on 3/12/2026 at 9:20 a.m., with the DON, the DON stated that it is important that the facility promptly accommodate Resident 78's needs, including repairing the wheelchair, when the resident when propelling due to the plastic tape.	F0908		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOYCE EISENBERG KEEFER MEDICAL CENTER D/P SNF	7150 TAMPA AVENUE , RESEDA, California, 91335

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0908 SS = D	Continued from page 86 During a review of facility's policy and procedure (P&P), titled, "Medical Equipment," reviewed on 4/2025, the P&P indicated, "Equipment that is broken, faulty or not working will contact maintenance immediately and central supply will make necessary repairs… The central supply will conduct performance and safety testing of all medical equipment before use." During a review of facility's P&P, titled, "Accommodation of Needs," reviewed on 4/2025, the P&P indicated, "Facility will create an individualized, home like environment, by making sure each resident has the right to resident and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other resident."	F0908		