

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055121	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/06/2025
NAME OF PROVIDER OR SUPPLIER  Pelican Ridge Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  466 Flagship Road Newport Beach, CA 92663	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and medical record review, the facility failed to ensure one of 12 sampled residents (Resident 2) was informed of the risks and benefits of proposed care, treatment, and treatment alternatives or options, and the choice to choose an alternative option in advance. * The facility failed to ensure Resident 2 and Family Member 1 were informed of the risks and benefits of using the IV fluid therapy, as well as providing alternative options for treatment. This failure had the potential for Resident 2 and Family Member 1 to not to be informed of the IV fluid solution and its potential effects, and prevent the resident from participating in choosing her treatment decisions. Findings: Medical record review for Resident 2 was initiated on 9/30/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS five-day assessment dated [DATE], showed Resident 2's BIMS Summary Score was 6, indicating severe cognitive impairment. Review of Resident 2's Order Summary Report showed the following orders:- dated 9/15/25, to administer Dextrose Intravenous Solution 5% (a sterile mixture of dextrose, a form of glucose, and water given directly into a patient's vein) use 1000 ml intravenously.- dated 9/16/25, to administer Dextrose Intravenous Solution 5% with multivitamin use 1000 ml bag to infuse 60 ml per hour ml/hr to provide 2 L. Review of Resident 2's IV Administration Report for September 2025 showed Resident 2 received the Dextrose Intravenous Solution 5% use 1000 ml intravenously on 9/15/25 at 2003 hours. Further review of Resident 2's medical record failed to show Family Member 1 was informed of the physician's order for Dextrose Intravenous Solution 5% intravenously, its potential effects and was provided the option to choose for alternative options. On 9/30/25 at 1640 hours, a telephone interview was conducted with Family Member 1. Family Member 1 stated the IV fluids were given to Resident 2 without her knowledge. Family Member 1 stated she was not informed of the IV fluid therapy and was afraid the IV therapy posed a dangerous risk for the resident. Family Member 1 further stated she saw the IV fluids infusing when she visited the resident. On 10/1/25 at 1035 hours, an interview and concurrent medical record review was conducted with RN 1. RN 1 verified Resident 2 was given the Dextrose Intravenous Solution 5% on 9/15/25. RN 1 stated she was not sure why the resident was started on IV therapy. RN 1 verified Resident 2's medical record failed to show documented evidence of the indication for Dextrose Intravenous Solution 5% ordered by the physician, notification regarding the use of IV fluids to Family Member 1. On 10/3/25 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed to ensure one of 12 sampled residents (Resident 9) was free from physical abuse . * Resident 9 was in the activities room when Resident 10 hit Resident 9's right hand. As a result, Resident 9 sustained redness to the right hand. This failure had the potential to negatively impact Resident 9's well-being. Findings: Review of the facility's P&amp;P titled Prevention, Reporting, and Correction of Inappropriate Conduct Including Abuse, Neglect and Mistreatment of Residents and Investigations of Injuries of Unknown Origin revised on 10/2024 showed it is the policy of the facility that all personnel, vendors and volunteers do no abuse or neglect any resident in the facility at any time for any reason. Abuse includes, but is not limited to physical, mental, verbal, sexual, or financial abuse. The facility maintains a zero tolerance to any abuse to residents from anyone including, but not limited to, facility staff, other residents, consultants. Review of the facility's P&amp;P titled General Documentation Guidelines revised on October 2024 showed 72-hour charting shall be initiated at the following times - this list is not all inclusive and nursing may use their judgment based on clinical condition. a. A significant change in physical, mental, or psychosocial status of the resident (progression, regression, new problems). b. An extraordinary event occurs (e.g., fall or injury). On 9/29/25, the CDPH L&amp;C Program received an SOC 341 form from the facility which showed on 9/27/25 at 1115 hours, Resident 10 hit Resident 9's hand which caused redness, while sitting at the same table during activities. Review of the facility's conclusion letter dated 10/3/25, showed the facility substantiated Resident 10 hitting Resident 9, sustaining redness to the right hand. a. Medical record review for Resident 9 was initiated on 10/2/25. Resident 9 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 9's MDS assessment dated [DATE], showed Resident 9 was severely cognitively impaired. Review of Resident 9's Progress Note dated 9/27/25, showed at 1115 hours, Resident 9 was hit on his right hand by another resident. On 10/2/25 at 1100 hours, an interview was conducted with Resident 11. Resident 11 stated Resident 10 gets agitated easily. Resident 11 stated they were in the activities room when the incident occurred, and witnessed Resident 10 hit Resident 9 at the table during an activity. Resident 11 stated Resident 9 had a red mark on the hand. On 10/2/25 at 1347 hours, an interview was conducted with Activities Assistant 2. Activities Assistant 2 stated Residents 9 and 10 were sitting next to each other in the activity room. Activities Assistant 2 stated Resident 10 made a fist and hit Resident 9 on the right hand. On 10/2/25 at 1417 hours, an interview was conducted with LVN 7. LVN 7 stated they were notified Resident 10 hit Resident 9. LVN 7 assessed Resident 9 and noted redness to the right hand. LVN 7 also stated residents are monitored for 72 hours following an abuse incident on every shift. Review of Resident 9's medical record failed to show documented evidence the resident was monitored for 72 hours post incident. On 10/3/25 at 1123 hours, an interview was conducted with RN 4. RN 4 stated monitoring following an abuse incident should be for 72 hours. RN 4 verified Resident 9 was not monitored and documented for 72 hours following the hitting incident. b. Medical record review for Resident 10 was initiated on 10/3/25. Resident 10 was admitted to the facility on [DATE]. Review of Resident 10's care plan for the use of Lithium (psychotropic medication) dated 5/12/22, showed the indication for the medication was for bipolar disorder manifested by being verbally/physically aggressive towards staff. Review of Resident 10's MDS assessment dated [DATE], showed a BIMS summary score of 14, indicating cognitively intact. Review of Resident 10's Change of Condition dated 8/29/25, showed at 1133 hours, Resident 10 was seen hitting another resident in the face. Review of Resident 10's IDT Care Conference dated 8/29/25, showed recommendations including a social services consult with the resident. Review of Resident 10's MAR for August 2025 showed on 8/30/25, there were seven episodes of physical aggression toward staff between 1900 hours to 0700 hours. Review of Resident 10's medical record failed to show documented evidence of a change in condition, progress notes, or family and MD notification for the incident on 8/29/25. Review of Resident 10's Change of Condition dated 9/27/25, showed Resident 10 hit another resident on the right hand. On 10/3/25 at 0952 hours, an interview was conducted with CNA 6. CNA 6 stated they questioned Resident 10 of the incident of hitting Resident 9 on the hand, however Resident 10 refused to answer. CNA 6 stated Resident 10 had a history of aggressive behavior and had an incident not too long ago. CNA 6 stated the previous incident occurred where Resident 10 hit another resident. On 10/30/25 at 1025 hours, an interview was conducted with CNA 7. CNA 7 stated Resident 10 gets agitated where they yell and curse. CNA 7 also stated Resident 10 gets agitated to the point where they feel Resident 10 would hit</p>		

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<p>F 0656</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and medical record review, the facility failed to develop and implement a comprehensive person-centered care plan to reflect the individual care needs for one of 12 sampled residents (Resident 2). * The facility failed to ensure a care plan was developed to address Resident 2's use of IV fluids. This failure posed the risk of not providing appropriate, consistent, and individualized care to the resident. Findings: Medical record review for Resident 2 was initiated on 9/30/25. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2's MDS five-day assessment dated [DATE], showed Resident 2's BIMS Summary Score was 6, indicating severe cognitive impairment. Review of Resident 2's Order Summary Report showed the following orders:- dated 9/15/25, to administer Dextrose Intravenous Solution 5% (a sterile mixture of dextrose, a form of glucose, and water given directly into a patient's vein) use 1000 ml intravenously.- dated 9/16/25, to administer Dextrose Intravenous Solution 5% with multivitamin use 1000 ml bag to infuse 60 ml per hour ml/hr to provide 2 L. Review of Resident 2's IV Administration Report for September 2025 showed Resident 2 received the Dextrose Intravenous Solution 5% use 1000 ml intravenously on 9/15/25 at 2003 hours. Further review of Resident 2's medical record failed to show a plan of care was developed for the use of intravenous therapy. On 10/1/25 at 1035 hours, an interview and concurrent medical record review for Resident 2 was conducted with RN 1. RN 1 verified Resident 2 was given the Dextrose Intravenous Solution 5% on 9/15/25. RN 1 verified Resident 2's medical record failed to show a plan of care was developed for the resident's use of Dextrose Intravenous Solution 5%. On 10/3/25 at 1615 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility P&amp;P review, the facility failed to provide the necessary care and services to attain or maintain the highest practicable well-being for one of 12 sampled residents (Resident 2). * The facility failed to weigh Resident 2 daily as ordered by the physician. * The facility failed to monitor Resident 2's condition after the resident sustained a bump on the head. These failures had the potential to negatively impact the resident's well-being. Findings: 1. Medical record review for Resident 2 was initiated on 9/30/25. Resident 2 was admitted to the facility on [DATE]. a. Review of Resident 2's Order Summary Report showed a physician's order dated 9/17/25, to obtain daily weights every day shift for three days for CHF. Review of Resident 2's MDS five-day assessment dated [DATE], showed Resident 2's BIMS Summary Score was 6, indicating severe cognitive impairment. Review of Resident 2's medical record failed to show documented evidence the resident's weight was monitored daily for three days as ordered by the physician. Additionally, there was no documented evidence to show whether the resident had refused to be weighed. On 10/3/25 at 1145 hours, an interview and a concurrent medical record review for Resident 2 was conducted with RN 3. RN 3 verified the physician's order for daily weight for three days was dated 9/17/25. RN 3 verified the resident's medical record failed to show daily weights were obtained or refused by the resident. b. Review of the facility's P&amp;P titled Condition Change of Resident revised November 2021 showed a change of condition can be anything that deviates from a resident's baseline status that requires physician notification for further assessment and/or a potential change in the treatment plan. Monitor resident's condition as often as the resident's condition warrants until stable and/or the resident is transferred for further care based on the professional judgment of the nurse in accordance with recognizable standards of care in the community. Document per facility policy. Review of the facility's P&amp;P titled General Documentation Guidelines reviewed October 2024 showed it is the policy of the facility to document relevant findings in the clinical record specific to each individual resident's needs and condition. A 72-hour charting shall be initiated at the following times - this list is not all inclusive and nursing may use their judgment based on clinical condition. a. A significant change in physical, mental, or psychosocial status of the resident (progression, regression, new problems); b. An extraordinary event occurs (e.g. fall or injury). Review of Resident 2's eInteract Change in Condition Evaluation dated 9/17/25, showed at 2242 hours, Resident 2 had a lump on the right side of the head with swelling observed. Review of Resident 2's medical record failed to show documented evidence the resident was monitored, care and safety measures were provided to the resident after a lump on the right side of the head with swelling was identified. On 10/2/25 at 0720 hours, an interview was conducted with LVN 4. LVN 4 verified Resident 2 was observed with a lump on the head with slight swelling. LVN 4 stated the resident's MD ordered for the resident to go to the acute care hospital. LVN 4 further stated Family Member 1 called the paramedics. LVN 4 stated the resident was not taken to acute care hospital by the paramedics because the resident's condition did not require for the paramedics to transfer the resident. LVN 4 stated the resident stayed in the facility. LVN 4 verified Resident 2's medical record failed to show documentation the resident was provided with follow up care related to the lump on the head with a slight swelling. On 10/2/25 at 1050 hours, an interview and a concurrent medical record review for Resident 2 was conducted with RN 3. RN 3 verified Resident 2 had a change in condition on 9/17/25 at 2242 hours, when the resident was observed with a lump on the right side of the head with swelling. RN 3 verified Resident 2's medical record failed to show the resident was monitored, care and safety measures were provided after the lump on the head was discovered. RN 3 stated the resident should have been observed for 72 hours, and the resident's condition should have been documented in the nurses progress notes. On 10/3/25 at 0735 hours, an interview was conducted with LVN 3. LVN 3 stated Resident 2 told him she leaned over and bumped her head over the bedside table. LVN 3 stated the resident should have been monitored for follow up care for her injury of having the lump on the head with slight swelling. LVN 3 stated he was not sure if he wrote Resident 2's name in the communication sheet for monitoring of the change of condition. On 10/3/25 at 1615 hours, an interview was conducted with the DON. The DON stated the licensed nurses should have documented resident's condition in the nurses progress notes. The DON was informed and acknowledged the above findings.</p>		

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<p>F 0849</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview, medical record review, and facility document review, the facility failed to ensure care was coordinated with the hospice provider for one of 12 sampled residents (Resident 8) reviewed for hospice. * The resident's hospice binder was not completed to show when the hospice provider visited Resident 8. This failure had the potential for the resident not receive the ordered hospice care services. Findings: Medical record review for Resident 8 was initiated on 10/2/25. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed physician's order dated 3/13/25, for hospice services to a hospice provider for diagnosis of terminal Cerebrovascular (CVA) Disease (a group of disorders that affect the blood vessels in the brain). Review of Resident 8's H&amp;P examination dated 3/15/25, showed Resident 8 had no capacity to understand and make decisions. Review of Resident 8's MDS assessment dated [DATE], showed Resident 8's BIMS score was 3, indicating severe cognitive impairment. On 10/2/25 at 0957 hours, an observation was conducted of Resident 8. Resident 8 was lying in bed awake, alert, and oriented to name with forgetfulness. On 10/6/25 at 0851 hours, an interview and concurrent medical record review was conducted with RN 2. The following was reviewed with RN 2:- Review of Resident 8's hospice sign in sheet and staff communication notes (undated) showed the HA's last visit with the resident was on 8/14/25, and the last hospice skilled nurse visit was on 9/16/25. - Review of Resident 8's plan of care effective 6/11/25, showed the assignment visit for the Hospice Aide was twice a week and skilled nurse was once a week. RN 2 verified the above findings. RN 2 stated this was her first time checking the hospice binder. RN 2 stated she was not responsible to check the hospice binder to make sure hospice disciplines complete their visits. In addition, RN 2 stated she was not instructed nor expected to document the hospice disciplines' visits. RN 2 stated the documentation was important and stated if it was not documented, it was not done. Furthermore, RN 2 stated the negative outcome would be Resident 8 would not receive the ordered hospice care services. On 10/6/25 at 0936 hours, an interview was conducted with LVN 6. LVN 6 stated Resident 8 was receiving hospice care. LVN 6 stated the hospice skilled nurse and Hospice Aide would check in with her when she was assigned to Resident 8. LVN 6 verified she did not document their visits in Resident 8's progress notes. In addition, LVN 6 stated she would not know the hospice disciplines' previous visits if she was not working. LVN 6 stated she has never checked Resident 8's hospice binder. LVN 6 stated the supervisors must be responsible in monitoring the hospice binder. Furthermore, LVN 6 stated negative outcome if hospice did not complete the visit and Resident 8 would not receive the hospice services per physician's order. On 10/6/25 at 1300 hours, a telephone interview was conducted with the Hospice Case Manager. The Hospice Case Manager stated she was assigned to Resident 8's care. The Hospice Case Manager stated the skilled nurses must visit once a week and the Hospice Aide must visit twice a week. The Hospice Case Manager stated when she visited Resident 8, she would sign and document in Resident 8's hospice binder after each visit and the Hospice Aide must sign the hospice binder. The Hospice Case Manager stated she did not monitor the other assigned disciplines if they had completed their scheduled visits for Resident 8 since it was not her responsibility to monitor. In addition, the Hospice Case Manager was informed of hospice sign in sheet, which showed last visit of Hospice Aide was 8/14/25, and skilled nurse's last visit was 9/16/25. The Hospice Case Manager stated she had visited Resident 8 last 9/24/25, however, she was not able to sign and document the hospice binder because the hospice binder was not available. The Hospice Case Manager stated she documented her visit in the hospice electronic health record. The Hospice Case Manager was asked if she recalled and documented the facility nurse's name who she checked in when she visited and she stated she did not get the facility nurse's name, however, she knows their faces. The Hospice Case Manager stated since she did not get the facility nurses' names whenever she visited Resident 8, she did not document which facility nurses she checked in and received updates. The Hospice Case Manager stated another case manager visited Resident 8 on 10/3/25, however, verified there was no documented evidence in Residents 8's hospice binder of the mentioned visit. The Hospice Case Manager stated it was part of their training (hospice provider) for the skilled nurses to sign in and document in the hospice staff communication note located in Resident 8's hospice binder after each visit. Furthermore, the Hospice Case Manager stated if it was not documented, it was not completed. On 10/6/25 at 1320 hours, an interview was conducted with the Hospice Patient Care Manager. The Hospice Patient Care Manager stated all hospice disciplines including the skilled nurses, hospice aides, social</p>		